



STANDARD MEDICARE SUPPLEMENT INSURANCE POLICY PLAN F HIGH DEDUCTIBLE

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Sanford Health Plan (Referred to in this contract as "we", "us", "our", or "the Plan") will provide the coverage stated in this policy subject to the provisions and limitations contained herein. We have issued this policy in consideration of the payment of the first premium and the statements made in your application.

Your Right To Examine And Cancel this Policy Within 30 Days

We want you to fully understand and be satisfied with your policy. If for any reason you are not satisfied with your policy, you may cancel it. Return the policy to us or to one of our authorized agents by midnight of the 30th day after you receive it. As soon as possible after we receive this policy, we will refund any premiums you have paid. The policy will be considered to have never been issued. If we have paid claims for you during this inspection period, we have the right to recover any amounts we paid.

Policy Term and Renewal

This policy is automatically renewed each month with your premium payments unless it is terminated by you or us. Renewal premiums must be paid on or before the renewal date or during the 30 days that follow. We cannot refuse to renew this policy or place any restrictions on it if you pay the premiums on time.

We may change the premium rates for this policy. The change may be due to a change in coverage or a new table of rates. We can only change your premium rate if we change it for all policies of the same class in this state. We will tell you in advance of any change in premium rate due to a new table of rates or a change in Medicare's benefit structure. Your rate changes automatically in January of each year after the 1st of the month following your birth month in which you enter a new age increment. Since benefits are tied to Medicare's deductible and coinsurance amounts, premium and benefit changes are expected to occur each January.

Notice to Buyer:

This policy may not cover all of the costs associated with medical care incurred by the Buyer during the period of coverage. You are advised to review carefully all policy limitations.

Read Your Policy Carefully. It is a legal contract between you and us.

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IMPORTANT INFORMATION

Your Medicare supplement healthcare coverage was developed to help you pay for some of your healthcare expenses not paid in full by Medicare. This *coverage only pays for those services accepted and approved by Medicare with the exception of benefits for medically necessary emergency care in a foreign country offered in Plans C through J.*

To understand your supplemental benefits, you must first understand your Medicare benefits. Therefore, it is very important that you read your *Medicare Handbook* carefully. If you do not have a Medicare Handbook, you may order one by calling your Social Security office.

Medicare benefits are divided into two categories: Medicare Part A and Medicare Part B.

- **MEDICARE PART A**

Medicare Part A helps pay for inpatient hospital care, care in a skilled nursing facility, home healthcare, and hospice services. We offer you supplemental benefits in all of these categories except for hospice services.

- **MEDICARE PART B**

Medicare Part B helps pay for physician services, outpatient hospital services, durable medical equipment, and a number of other medical services and supplies that are not covered by Medicare Part A. We offer you supplemental benefits in all these categories as stated in *SECTION III: Schedule of Benefits*, with the addition of benefits for medically necessary emergency care in a foreign country offered in Plans C through J.

DEFINITIONS

Definitions of Terms Included In This Policy

This section provides an alphabetical list of certain terms and their meaning as used in this policy. Defined terms are capitalized wherever they occur in the policy.

Accident means injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily injury or any other cause, and occurs while insurance coverage is in force. This definition does not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan.

Assignment means a provider or supplier agrees to accept Medicare's approved charge as full payment for a service or supply. This does not include any deductible or coinsurance amount you are responsible for paying.

Benefit Period means a period of consecutive days that begins with the first day (not included in the previous spell of illness) on which you are furnished inpatient hospital, skilled nursing, or rehabilitation services by a qualified provider in a month for which you are entitled to Medicare Part A benefits. A benefit period ends when you have been out of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row (including the day of discharge).

Calendar Year means the twelve-month period that begins on January 1st and ends with December 31st. When you first become covered under this policy, the first Calendar Year begins for you on the effective date of your policy and ends on the following December 31st.

Co-payment or Coinsurance means that portion of expenses which must be paid by you.

Covered Services means medically necessary, Medicare-approved services and supplies that qualify for payment of benefits under this policy.

Custodial Care means Room and Board and other care which is provided for a person due to a mental or physical condition mainly to aid the person in daily living or meeting personal needs.

Deductible (may also be called Out-of-Pocket Deductible or Medicare Deductible) means the amount of covered expenses which you must pay yourself before benefits will be paid.

Emergency Care means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention, as determined by a prudent layperson, could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Healthcare expenses means expenses of health maintenance organizations associated with the delivery of healthcare services, which expenses are analogous to incurred losses of insurers.

Such expenses shall not include: home office and overhead costs; advertising costs commissions and other acquisition costs taxes, capital costs, administrative costs and claims processing costs.

Hospital means a place which provides care and treatment for sick or injured persons as resident bed patients. It must also have:

1. A Registered Graduate Nurse (R.N.) on duty or on call at all times to supervise 24-hour nursing service;
2. The means for diagnosis, treatment and surgery on its premises or in facilities available on a contractually prearranged basis; and
3. A physician is present or on call at all times to supervise all care.

It must be licensed by the laws of the jurisdiction where it is located and run as a Hospital as defined by those laws.

Its main purpose must not be to provide rest, educational or custodial care, care for the aged-or treatment such as that provided by a convalescent home or sanitarium. A place that treats mental or nervous disorders, or provides treatment of a physical disability, will be deemed a Hospital even if it does not have a means for surgery, if it qualifies in all other respects.

Injury means accidental bodily injury sustained by the insured which is the direct cause of loss, independent of disease, bodily infirmity or other causes. This definition does not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan.

Inpatient Lifetime Reserve Days means the additional non-renewable 60 days of hospital coverage provided under Medicare Part A for an admission which exceeds 90 days. **Important Note:** Once you use an Inpatient Lifetime Reserve Day, it is not replaced because Inpatient Lifetime Reserve Days are non-renewable.

Medicare means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965" as then constituted or later amended.

Medicare Part A means insurance to cover Hospital expenses, such as Room and Board and other inpatient Hospital services.

Medicare Part B means insurance to cover medical expenses, such as Physicians' services, outpatient Hospital services and a number of other non-Hospital medical services and supplies.

Medicare Eligible Expenses means expenses which are of the kind covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

Medicare Summary Notice (MSN) is a form summarizing the action Medicare took on your claim and what amount, if any, Medicare paid for the services you received.

Nurse means one of the following licensed professionals:

1. Registered Nurse (R.N.);
2. Licensed Practical Nurse (L.P.N.); or
3. Licensed Vocational Nurse (L.V.N.).

Physician means a person who is licensed to practice the healing arts. The Physician must perform only those services permitted by his or her license. Examiners as a physician, or similar boards in other states, and those licensed persons required by State insurance laws to be reimbursed for services legally performed and covered under this policy. This definition will apply to this policy only to the extent that it is not more restrictive than the definition of *physician* as defined in the Medicare program. Services rendered otherwise shall not be covered by this Policy. "Physician" does not include you or any immediate family member. This exclusion does not apply to those in areas in which the immediate family member is the only physician in the area and acting within the scope of their normal employment.

Policyholder means you, the person who signed for this policy.

Provider means any licensed or approved healthcare professional including a physician, psychologist (who has a doctorate degree in psychology with two years clinical experience or who meets the standards of a national register), a chiropractor, optometrist, podiatrist, physical therapist, oral surgeon, certified registered nurse anesthetist, or any other provider approved by Medicare.

Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. This definition does not include sickness or diseases for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan.

Skilled Nursing Facility means a place which, by law, provides care and treatment to persons who are convalescing as resident bed patients' from a Sickness or Injury after a Hospital stay. It must also:

1. Qualify as a Skilled Nursing Facility under Medicare, or be qualified to receive such approval if requested;
2. Have a registered graduate nurse (R.N.) on duty or on call in the place at all times to supervise 24-hour nursing service;
3. Have a Physician to supervise the operation of the place, and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

Total Disability or Totally Disabled means your inability, as a result of injury or sickness, to perform the substantial and material duties of your own occupation or any occupation for which you are fitted by reason of education, training or experience.

We, us or our means Sanford Health Plan.

You or Your means the insured under this policy.

SECTION I
SERVICES NOT COVERED

We will not allow benefits for:

- Services not allowed by Medicare as Benefits, except as stated in *Section III, Schedule of Benefits*.
- Services denied by Medicare, except as stated in *Section III, Schedule of Benefits*.
- Services that would duplicate benefits provided by Medicare.
- Expenses incurred prior to this policy's effective date or while your policy is not in force.

If you have any questions after reading your Medicare Handbook and this Policy, please call Member Services at (605) 328-6800 or toll free at 1-800-752-5863.

SECTION II POLICY PROVISIONS

The documents that make up your contract with us consist of:

- The application you submitted,
- This benefits policy, and
- Any amendments.

A. Persons Eligible for Coverage

To be eligible for coverage under this policy, you must be:

1. Eligible for Medicare; and
2. Enrolled in both Medicare Parts A and B.
3. You must physically reside in one of these counties:

In South Dakota:

Aurora	Clark	Fall River	Hyde	Marshall	Spink
Beadle	Clay	Faulk	Jackson	Meade	Stanley
Bennett	Codington	Grant	Jerauld	Mellette	Sully
Bon Homme	Corson	Gregory	Jones	Miner	Todd
Brookings	Custer	Haakon	Kingsbury	Minnehaha	Tripp
Brown	Davison	Hamlin	Lake	Moody	Turner
Brule	Day	Hand	Lawrence	Perkins	Union
Buffalo	Deuel	Hanson	Lincoln	Potter	Walworth
Butte	Dewey	Harding	Lyman	Roberts	Yankton
Campbell	Douglas	Hughes	Mccook	Sanborn	Ziebach
Charles Mix	Edmunds	Hutchinson	Mcpherson	Shannon	

In Iowa: Clay, Dickinson, Emmet, Lyon, O'Brien, Osceola, and Sioux.

B. Effective Date of Insurance

We must receive your Application for Coverage prior to the requested effective date. The effective date of insurance shall then be the date listed on your Application for Coverage or upon underwriting approval (if applicable), whichever is later.

C. Premiums

The premium rate for your coverage is shown in your *Outline of Coverage*, labeled "*Monthly Premium Information*." Regular premiums may be paid by check annually (once a year), semiannually (twice a year), or quarterly (four times a year). Monthly premiums (twelve times a year) must be paid via automatic account withdrawal only.

1. **Premium Changes.** We can only change your premium rate if we change it for all policies of the same class in this state. We will tell you at least 30 days in advance of any change in premium rate due to a new table of rates or a change in Medicare's benefit structure. Since benefits are tied to Medicare's deductible and coinsurance amounts, premium and benefit changes are expected to occur each January.

We have the right to change your rates upon an increase in your age. Premium changes due to an increase in age automatically occur the first of the month following your birth month in which you enter a new age increment.

2. **Payment of Premium.** Each premium is due at the end of the period for which the preceding premium was paid. You must make premium payments in the required amount according to our agreed schedule of payments for the duration of the contract.
3. **Lapse in Coverage.** If any renewal premium is not paid within the time allowed for payment, coverage will lapse on the last day of the period for which the premium is paid. If the premium is not paid by that date, the grace period will begin.
4. **Grace Period.** A grace period of 31 days will be granted for the payment of each renewal premium. During this grace period, the policy shall continue in force.
5. **Reinstatement.** If you fail to pay the renewal premium within the 31-day grace period, your coverage will lapse. You may request reinstatement of this policy by submitting an *Application for Coverage*. We will give you written notice of our decision to accept or deny your application. If reinstated, this policy will cover only claims that occurred after the date of reinstatement.

Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid. In order to be reinstated, you must pay any premiums due from your previous enrollment in the plan.

D. How Payment Works

When a physician or supplier agrees to accept the charge approved by Medicare as full payment for covered services, he or she is said to accept *assignment*. All physicians who participate in the Medicare program agree to accept assignment. If you are not sure if your physician participates in the Medicare program, ask and he or she will tell you.

If a physician does not accept assignment, he or she may collect more than Medicare's approved amount. If you purchased Plan F or I, we will pay this difference for you when this happens.

If your provider accepts assignment, we will send our payment directly to that provider. If your provider does not accept assignment, we send our payments to you or, in the event of your death, to your estate.

E. Filing Claims

You do not need to file a claim for your services. By law, physicians or other suppliers must fill out claim forms for you and send them to Medicare, even if they do not accept assignment. We will accept notice from Medicare Carriers on claims submitted on your behalf by physicians and suppliers or you may submit the Medicare Summary Notice (MSN). Notice of claims should include your name and policy number.

You should always make sure your providers know that you have supplemental coverage with us. When you receive health services in your home state, Medicare will automatically send your claim to us.

Out-of-State Services

If you receive health services outside of your state, the provider will submit your claim to the Medicare office in that state. After the office processes the claim, you will receive a Medicare Summary Notice (MSN). If the *Notes* section of the MSN says that the information is being sent to your private insurer, we will automatically receive the MSN. If the MSN does not say your private insurer is receiving the information, you need to send the MSN to us so we can process your Medicare supplement benefits. Be sure your identification number and mailing address are shown accurately on the MSN form. You do not need to complete a claim form, just send the MSN, and keep a copy for your own records. Send your MSN to:

*Sanford Health Plan
Medicare Supplement Claims
P.O. Box 91110
Sioux Falls, SD 57109-1110*

F. Authorized Policy Changes

No agent, employee or representative of ours has authority to change this policy or waive any of its provisions. No change in this policy shall be valid until approved by an executive office of the company and unless such approval be endorsed hereon or attached hereto. Unless the change in benefits is required by law, your acceptance of an amendment must be in writing if the amendment reduces or eliminates benefits or increases benefits accompanied by an increase in premium during the policy term.

G. Medicare Deductible and Coinsurance Changes

If Medicare changes its deductible and co-insurance amounts, your policy will automatically change to cover the amounts determined by Medicare. Your premium may also be changed at this time. We will give you appropriate notice of such change. This usually happens on January 1st of each year.

H. When Coverage Ends

Your coverage will end immediately if any of the following occurs:

1. You fraudulently misrepresent or conceal material facts in your application. If this happens, we will recover any claim payment we made, minus any premium paid.
2. You fail to pay your premium by the end of the 31-day grace period.
 - a. If you pay by automatic account withdrawal, your coverage will be terminated upon Plan notification of non-sufficient funds in your account.
 - b. If you pay by check quarterly, semiannually or annually, you coverage will be terminated the first of the month following the month for which premium was paid.
3. You terminate this policy by giving written notice of termination to Sanford Health Plan. Your coverage will be terminated on the first of the month following the month in which we receive your written notice.
4. You are no longer eligible according to the criteria set forth under “*Persons Eligible for Coverage*” in the *Policy Provisions* Section.

I. Effects of Termination

If your policy is terminated for misrepresentation or the concealment of material facts we will not pay for any services or supplies provided after the date the policy is

terminated; we will retain legal rights, including the right to sue based on concealment or misrepresentation; and we may, at our option, declare the policy void.

If, at any time while your insurance under this policy is in effect, we become aware that you are no longer enrolled in both Medicare Parts A and B, we will notify you and you will need to provide the appropriate information to us to process any claim. Failure to be enrolled in Medicare Parts A and B will result in termination of your policy.

If your policy is terminated for reasons other than concealment or misrepresentation of material facts, we may stop payment for any services or supplies the day your policy is terminated.

An exception to this applies in the case of a continuous loss that commenced while this policy is in force. If you receive covered professional or facility services as an inpatient of a hospital or skilled nursing facility on the date this policy terminates, payment for these covered services will end on the earliest of the following:

- the date you are first discharged from the facility following termination of this policy;
- the date the policy coverage period would have ended if this policy had not been terminated, that is, the end of the calendar year during which you were an inpatient;
- the date your Medicare benefits are exhausted if no **additional benefits would** otherwise have been covered under this policy had it remained in effect; or
- payment of maximum benefits.

J. Suspension of Coverage and Reinstatement

1. During Medicaid Eligibility

At your request, your Policy will be suspended for a period of time not to exceed twenty-four (24) months during which you have applied for and are entitled to medical assistance under Title XIX of the Social Security Act (Medicaid). You must notify us within ninety (90) days after the date you have become entitled to such assistance.

Provided you notified us within ninety (90) days after the date you have become entitled to Medicaid, we shall return to you that portion of the premium you paid which is attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

If your entitlement to this assistance is terminated during the twenty-four (24) month period, and you notify us within 90 days of this termination, coverage that is substantially the same as that in effect at the point of suspension shall be reinstated at premium classification terms that would have applied to you had your coverage never been suspended. You must pay the premium attributable to the period, effective as of the date of termination of Medicaid entitlement.

Reinstatement of Coverage:

- will not provide for any waiting period for treatment of preexisting conditions;
- will provide coverage substantially equivalent to the coverage in effect before the date of suspension; and
- will provide for premium classification on terms at least as favorable to you as the premium classification terms that would have applied had the coverage not been suspended.

2. During Enrollment in Group Health Plan

You may request a suspension in coverage if you are under age 65, enrolled in Medicare benefits as the result of disability, and enrolled in a group health plan sponsored by you current or former employer or employee organization. To suspend your policy, you must notify us within 90 days after the date you become enrolled in such group coverage. We shall return to you that portion of the premium paid by you which is attributable to the period of the other coverage, subject to adjustment for paid claims.

If a suspension occurs and you lose entitlement to the group coverage, your Medicare supplement policy will be reinstated automatically as of the date your group coverage is terminated if you notify us that you lost your group coverage. You must notify us within 90 days after the date of such loss.

Reinstatement of Coverage:

- will not provide for any waiting period for treatment of preexisting conditions;
- will provide coverage substantially equivalent to the coverage in effect before the date of suspension; and
- will provide for premium classification on terms at least as favorable to you as the premium classification terms that would have applied had the coverage not been suspended.

K. Our Right to Recover Payments

If for any reason we make payment under this policy in error, we may recover the amount we paid.

1. Subrogation

Once you receive benefits under this policy arising from an illness or injury, we will assume any legal right you have to collect compensation, damages, or any other payment related to the illness or injury, including benefits from any of the following:

- The responsible person's insurer;
- Uninsured motorist coverage;
- Underinsured motorist coverage; or
- Other insurance coverage.

You agree to the following:

- You will let us know about any potential claims or rights of recovery related to the illness or injury;
- You will furnish any information and assistance that we may reasonably require to enforce our rights under this policy;
- You will do nothing to prejudice our rights and interests;
- You will not compromise, settle, surrender, or release any claim or right of recovery described above, without getting our written permission; and
- You must reimburse us to the extent of benefit payments made under this policy if payment is received from the other party or parties.
- You must notify us if you have the potential right to receive payment from someone else.
- You must cooperate with us to ensure our rights to subrogation are protected.

L. Notice of Communication

You may send any written notice or communication to our office at:

*Sanford Health Plan
Member Services
P.O. Box 91110
Sioux Falls, SD 57109-1110*

Any notice from us is acceptable when sent to your address as it appears on our records

M. Legal Actions

No legal or equitable action may be brought against us because of a claim under this policy, or because of the alleged breach of this policy sooner than sixty (60) days from the filing of a claim and not more than three (3) years after the end of the calendar year in which the healthcare services or supplies were provided.

N. Time Limit on Certain Defenses

After 2 years from the effective date of this policy no misstatements, except fraudulent misstatements, made by you in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability commencing, after the expiration of such 2 year period.

No claim for illness or injury commencing after two (2) years from the effective date of this policy will be reduced or denied on the grounds that the disease or physical condition not excluded from coverage by name or specific description effective on the date of service had existed prior to the effective date of coverage of this policy.

O. Nonassignment

Benefits for covered services in this policy are for your personal benefit and cannot be transferred or assigned to anyone else. Any attempt to assign this policy or rights to payment will be void.

P. Conformity With State And Federal Laws

If any provision of the policy on its effective date is in conflict with the laws of your State on that date, it is amended to conform to the minimum requirements of such laws.

If at any time during the life of the policy, federal or state law changes which would require a corresponding change in the coverage, we reserve the right, subject to regulatory approval, to change policy language, benefits or premium rates, but only insofar as necessary to comply with the changes in law.

To the extent not superseded by the laws of the United States, this policy will be construed in accordance with and governed by the laws of the State. Any action brought because of a claim under this policy will be litigated in the state or federal courts located in your State of residence and no other.

Q. Time Periods

All periods begin and end at 12:00 A.M. Standard Time at your residence.

R. Disclosure Statement

You hereby expressly acknowledge your notice that this policy is a contract solely between you, the policyholder, and us, Sanford Health Plan. You further acknowledge and agree that you have purchased this policy based upon representations by us or our authorized representatives. No person, entity, or organization other than us is accountable or liable to you for any obligations created under this policy. This paragraph does not create any obligations on our part in addition to those created under the provisions of this policy.

SECTION III

SCHEDULE OF BENEFITS

PLAN F HIGH DEDUCTIBLE STANDARD MEDICARE SUPPLEMENT SCHEDULE OF BENEFITS

Standardized Medicare supplement benefit high deductible plan "F" includes: One hundred percent of covered expenses following the payment of the annual high deductible plan "F" deductible. The annual high deductible plan "F" deductible consists of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and are in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible is based on the calendar year. It is adjusted annually by the Secretary of the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year and rounded to the nearest multiple of \$10.

Basic "Core" Benefits

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day to the 90th day, inclusive, in any Medicare benefit period;
2. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem rate, or if different than the DRG day outlier per diem rate, the per diem rate at which Medicare was paying on the last day prior to exhaustion of Medicare hospital inpatient coverage, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the Plan's payment as payment in full and may not bill the insured for any balance;
4. Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, in accordance with federal regulations.
5. Coverage for the coinsurance amount or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

Additional Benefits

6. Medicare Part A deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount for each benefit period;

7. Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;
8. Medicare Part B deductible: Coverage for all of the Medicare Part B deductible amount for each calendar year regardless of hospital confinement;
9. Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, if the care would have been covered by Medicare if provided in the United States and if the care began during the first 60 consecutive days of each trip outside the United States, subject to a deductible for each calendar year of \$250 and a lifetime maximum benefit of \$50,000. For purposes of this benefit, the term “emergency care” means care needed immediately because of an injury or an illness of sudden and unexpected onset; and
10. One hundred percent of the Medicare Part B excess charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.