Outline of Medicare Supplement Coverage of South Dakota

Benefit Plans A, C, F High Deductible & F are offered by Sanford Health Plan

Medicare
SUPPLEMENT

Medicare supplement insurance can be sold in only twelve standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in your state.
Basic Benefits for Plans A-J:
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or, in the case of hospital outpatient department services under a prospective payment system, applicable copayments. **Blood:** First three pints of blood each year.

A	B	C	D	E	F / F*	G	H	I	J / J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
				Non-Medicare Covered Preventive Care					Non-Medicare Covered Preventive Care

[shaded box] Indicates plans offered by Sanford Health Plan

* Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year $[1,900] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are $[1,900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible of $250 per year.

BENEFIT PLANS K & L

Basic Benefits for K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

	K[1]	L[1]
Part A Coinsurance & Hospital Benefits	100%	100%
Part B Coinsurance	50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Hospice Care	50%	75%
Blood	50% of Medicare-eligible expenses for the first three pints of blood	75% of Medicare-eligible expenses for the first three pints of blood
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Foreign Travel Emergency		
At-Home Recovery		
Out of Pocket Annual Limit[2]	$4,440	$2,220

[1] Plans K and L provide for different cost-sharing for items and services than Plans A-J.

Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductible for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.

[2] The out-of-pocket annual limit will increase each year for inflation.

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your Policy, you may return it to Sanford Health Plan. You can return the Policy to the agent that sold it to you or send it back to: PO Box 91110, Sioux Falls, SD 57109-1110. If you send the Policy back to us within 30 days after you receive it, we will treat the Policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new Policy and are sure you want to keep it.

NOTICE

Items in brackets "[ ]" follow current Medicare amounts.

Service areas includes all of South Dakota counties except Pennington.

This Policy may not fully cover all of your medical costs.

Neither Sanford Health Plan nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your Social Security Office or consult *"The Medicare and You Handbook"* for more details.

PLEASE READ YOUR POLICY VERY CAREFULLY. This is only an outline describing your Policy's most important features. The Policy is your insurance contract. You must read the Policy itself to understand all of the rights and duties of both you and Sanford Health Plan.

Plan A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,068]	$0	$[1,068](Part A deductible)
61st through the 90th day	All but $[267] a day	$[267] per day	$0
91st day and after:			
-While using 60 lifetime reserve days (non-renewable)	All but $[534] a day	$[534] per day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0**
-Beyond additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-certified facility within 30 days after leaving the hospital			
First 20 days	All Medicare-approved amts.	$0	$0
21st through the 100th day	All but $[133.50] a day	$0	Up to $[133.50] a day
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan A
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	20%	$0
CLINICAL LABORATORY SERVICES —TESTS FOR DIAGNOSTIC SERVICES	Generally 100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	Generally 100%	$0	$0
—Durable medical equipment			
First $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	20%	$0

PLAN C
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,068]	$[1,068] (Part A deductible)	$0
61st through the 90th day	All but $[267] a day	$[267] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
-Beyond additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-certified facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through the 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies that you are terminally ill & you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additioanl 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[135] of Medicare-approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $[135] of Medicare-approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	20%	$0
CLINICAL LABORATORY SERVICES —TESTS FOR DIAGNOSTIC SERVICES	Generally 100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	Generally 100%	$0	$0
—Durable medical equipment			
First $[135] of Medicare-approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – **NOT COVERED BY MEDICARE** Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $[250] each calendar year	$0	$0	$[250]
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN F OR HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,068]	$[1,068] (Part A deductible)	$0
61st through the 90th day	All but $[267] a day	$[267] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
-Beyond additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-certified facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through the 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additioanl 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F: MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$1,790] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1,790]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[135] of Medicare-approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges. (above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $[135] of Medicare-approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	20%	$0
CLINICAL LABORATORY SERVICES —TESTS FOR DIAGNOSTIC SERVICES	Generally 100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	Generally 100%	$0	$0
—Durable medical equipment			
First $[135] of Medicare-approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	20%	$0

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $[250] each calendar year	$0	$0	$[250]
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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Your premium is based on your age and plan benefits. Sanford Health Plan can only raise your premium if we raise the premium for all policies like yours in this State. If it becomes necessary, due to heavy utilization, for us to change our rate structure on the same year you have a birthday, you may sustain both increases the same year.

Sanford Health Plan
South Dakota Medicare Supplement Premium Rates
Non-Tobacco User Rates

Age	Plan A	Plan C	Plan F	Plan F - High Deductible
Under 65 Disabled	$ 109.36	$ 198.60	$ 219.58	$ 98.80
65 – 67	75.40	137.00	151.46	68.16
68	82.58	150.02	165.87	74.65
69	87.21	158.41	175.15	78.81
70	90.67	164.71	182.10	81.95
71	94.78	172.16	190.33	85.65
72	98.40	178.73	197.62	88.92
73	102.03	185.32	204.89	92.21
74	105.68	191.94	212.21	95.51
75	109.36	198.60	219.58	98.80
76	113.03	205.31	227.01	102.16
77	116.74	212.04	234.45	105.50
78	120.48	218.82	241.94	108.87
79	124.22	225.64	249.47	112.26
80	129.74	235.70	260.59	117.26
81	134.07	243.59	269.29	121.18
82	139.28	253.02	279.73	125.89
83	145.12	263.67	291.50	131.18
84	151.42	275.13	304.15	136.88
85 – 89	159.40	289.62	320.17	144.07
90+	160.11	290.92	321.61	144.72

Sanford Health Plan
South Dakota Medicare Supplement Premium Rates
Tobacco User Rates

Age	Plan A	Plan C	Plan F	Plan F - High Deductible
Under 65 Disabled	$ 121.51	$ 220.66	$ 243.98	$ 109.79
65 – 67	83.77	152.23	168.28	75.74
68	91.75	166.71	184.30	82.94
69	96.90	176.01	194.60	87.56
70	100.76	183.01	202.34	91.06
71	105.31	191.28	211.49	95.18
72	109.34	198.58	219.58	98.79
73	113.38	205.90	227.65	102.46
74	117.42	213.27	235.80	106.11
75	121.51	220.66	243.98	109.79
76	125.59	228.12	252.23	113.50
77	129.73	235.61	260.50	117.22
78	133.87	243.13	268.82	120.97
79	138.02	250.71	277.20	124.73
80	144.16	261.90	289.54	130.29
81	148.97	270.65	299.21	134.64
82	154.74	281.15	310.82	139.88
83	161.25	292.98	323.88	145.75
84	168.24	305.71	337.95	152.08
85 – 89	177.11	321.79	355.75	160.09
90+	177.91	323.24	357.35	160.81

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