Outline of Medicare SELECT Supplement Coverage of South Dakota

Benefit Plans A, C and F are offered by Sanford Health Plan

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. Medicare SELECT plans contain restrictions on your use of providers.
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

Indicates SELECT 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.

You do not need more than one Medicare Supplement Policy. You must be enrolled in Part A and Part B Medicare coverage and use a Medicare-certified hospital.

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 include: Aurora, Beadle, Bon Homme, Brookings, Brule, Buffalo, Charles Mix, Clark, Clay, Codington, Davison, Day, Deuel, Douglas, Grant, Gregory, Hamlin, Hanson, Hutchinson, Jerauld, Kingsbury, Lake, Lincoln, Lyman, McCook, Miner, Minnehaha, Moody, Roberts, Sanborn, Spink, Tripp, Turner, Union & Yankton.

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.

Sanford Health Plan offers Medicare Supplement plans which do not restrict your use of hospitals. You have the right to purchase Standard Plans A, C, F and F high deductible at anytime.

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.***

Medicare SELECT Provider Restrictions

This is a Medicare SELECT supplement insurance policy. Facility expenses will be denied if you receive inpatient hospitalization services or outpatient surgery services in a non-Network Facility.

The full benefits of your coverage will be paid anywhere if:

1. Services (other than outpatient surgery) are not provided in a hospital setting (i.e. services are provided in the physician's offices, in another office setting, or in a skilled nursing facility); or

2. Policyholders require services while traveling outside the service area, on the 1st through the 90th day of each trip; or

3. The services are provided for symptoms requiring emergency care or are immediately required for unforeseen illness, injury or other condition, and it is not reasonable to obtain such services through the Network Hospitals; or

4. Services are not available at a Network Hospital.

Other than outpatient surgery as noted above, there are no restrictions on benefits for services received in a non-hospital setting beyond standard limitations of this policy.

Non-Network Hospital Admission Procedures

Prior to admission to a non-Network Hospital, the policyholder, either directly or through the policyholder's physician, should contact Sanford Health Plan's Member Services Department. A Member Service Representative will confirm whether the required services are available from a Network Hospital, and if not available, will assist the policyholder in locating a hospital that provides the necessary service. Utilizing Sanford Health Plan's Member Services prior to use of a non-Network Hospital eliminates the need for retrospective inquiry as to the legitimacy of the filed claim.

These non-Network Hospital Admission Procedures do not apply in emergency situations, while the insured is traveling outside the service area, or when being admitted to a Network Hospital.

Quality Assurance

When you purchase a Sanford Health Plan SELECT Plan, you agree to use a Sanford Health Plan Network Hospital or outpatient surgery center whenever possible. Sanford Health Plan ensures high quality healthcare through our Quality Improvement Program. Our Quality Improvement Program allows us to provide accountability for the quality of health care delivery and service. We have a committed Board of Directors and Medical Management Quality and the Health Plan Quality Improvement Committees who develop and carry out a Quality Assurance Plan that has a systematic approach to assessing, measuring, defining and resolving medical care, and behavioral health and service issues.

Complaint & Grievance Procedures

We seek to provide quality administration and services to insureds of our Medicare SELECT supplement insurance plans and Network Hospitals. However, from time to time, an insured may not be fully satisfied with the administration, claims practices, or services we provide; or an insured may not be fully satisfied with the services provided by a Network Hospital. It is the policy of Sanford Health Plan to make reasonable efforts to resolve member and provider complaints. A process has been established for members (or their designees) and providers to use when they are dissatisfied with the Plan, its providers, or processes. The complaint and grievance procedure, along with a detailed description of how to file a complaint or grievance, will be described in the policy and outline of coverage. Policyholders may submit a grievance within 180 days from the date the complaint or grievance arose.

Complaints While Staying At A Network Hospital

If, while staying at a Network Hospital, You have a complaint regarding the hospital's services being provided, You may contact our Member Services Department at 1-800-752-5863 to express the complaint. Our Member Services Representatives will relay the complaint to the Hospital's Administrator for prompt resolution.

Other Complaints

If you have questions or are dissatisfied with the quality of Sanford Health Plan services, or want to contest the disposition of a claim, You may direct such inquiries to Member Services 1-800-752-5863, or the address shown on the back of the policyholder identification card, without initiating a formal grievance.

Complaints and Appeals can be made for up to 180 days from a denial notification.

Complaint and Post-Service Appeal Procedure

If any member or authorized representative acting on behalf of the member, has a question, complaint or other problem regarding claims payment for a post service(s) or those services already received, any aspect of the Plan's services, his or her relationship with the Plan and its providers other than a complaint regarding certification, or authorization decision, the member or the authorized representative should contact the Plan by calling or sending a written complaint to the following address:

Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110
Phone: 1-800-752-5863 or
(605) 328-6800

The Plan's goal is to make a decision and notify the member in writing of its proposed resolution within sixty (60) days of receipt of complaint. If the issue unsatisfactorily resolved the member will be informed of his or her right to appeal the decision. Member notification of the complaint response will be made in writing or by telephone, which will be logged for reference. Any adverse decision notification will advise the member of the opportunity to submit written comments, documents or other information related to the appeal. For complaints related to the quality of care, the Plan will, at a minimum, state that the member's complaint was received and investigated.

If the member or a member's authorized representative appeals an adverse complaint response, a thorough investigation of the substance of the appeal including any aspects of clinical care involved will be conducted by an individual designated by the Plan. A person who was not the subordinate of any person involved in the initial determination will review the complaint/post-service appeal.

The Plan will document the substance of the appeal and any actions taken. Full investigation of the substance of the appeal, including any aspects of clinical care involved will be coordinated by the Complaint Coordinator. For medical necessity post-service appeals only, a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will review the appeal.

If the post-service appeal response is adverse, the member shall be informed of their additional right to contact the SD Division of Insurance or through a court of law.

SD Dept of Commerce
Division of Insurance
500 East Capitol
Pierre, SD 57501
Fax: (605) 773-5369
Phone: (605) 773-3563

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 recieve 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
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
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	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

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

MONTHLY PREMIUM INFORMATION

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 SELECT Monthly Premium Rates

Age	Plan A	Plan C	Plan F
Under 65 Disabled	$102.13	$142.57	$152.56
65 – 67	79.58	94.14	93.49
68	82.35	106.12	105.38
69	82.66	106.53	105.78
70	96.39	126.03	125.26
71	96.75	126.51	125.73
72	97.11	126.98	126.20
73	97.48	127.46	126.67
74	97.83	127.93	127.15
75	102.13	142.57	152.56
76	102.51	143.09	153.11
77	102.89	143.61	153.68
78	103.26	144.15	154.24
79	103.64	144.67	154.80
80	104.96	156.05	166.90
81	105.35	156.61	167.52
82	105.73	157.18	168.12
83	106.11	157.75	168.73
84	106.49	158.31	169.33
85 – 89	107.83	160.32	171.48
90 & Over	108.33	161.04	172.25

P.O. Box 91110
Sioux Falls, SD 57109-1110
(605) 328-7200
1-888-605-9277