South Dakota [2021]

Outline of Coverage for Medicare Select Supplement – MACRA

SANFORD
HEALTH PLAN

South Dakota Outline of Coverage for Medicare Select Supplement – MACRA

Benefit Plans A, C, D, F, High Deductible F, G, High Deductible G, and N are offered by Sanford Health Plan.

This chart shows the benefits included in each of the standard Medicare Select supplement plans. Every company must make Plan "A" available. Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F. High deductible G is available for effective dates on or after 01/01/2020. Some plans may not be available in your state. Plans E, H, I, and J are no longer available for sale.

Basic Benefits:

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 copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.

Blood – First three pints of blood each year.

Hospice – Part A coinsurance.

A	B	C	D	F F*
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible
				Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

G G**	K	L	M	N
Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
Part B Excess (100%)				
Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
	Out-of-pocket limit $[6,220]; paid at 100% after limit reached	Out-of-pocket limit $[3,110]; paid at 100% after limit reached		

Indicates plans offered by Sanford Health Plan.

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,370] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2,370]. 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 do not include the plan's separate foreign travel emergency deductible.

**Plan G also has an option called a high deductible plan G. This high deductible plan pays the same benefits as Plan G after one has paid a calendar year [$2,370] deductible. Benefits from high deductible Plan G will not begin until out-of- pocket expenses exceed [$2,370]. High deductible plan G does not cover the Medicare Part B deductible. However, your payment of the Part B deductible amount counts toward the accumulation of out-of-pocket expenses.

Benefit Chart of Medicare Supplement Plans Sold for effective dates after December 31, 2019

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: The check marks (✓) in the Medigap chart mean the benefit is included with this plan option.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K[2]	L[2]	M	N[3]	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B Coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in [2021][2]					[$6,220][2]	[$3,110][2]				

Indicates plans offered by Sanford Health Plan.

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of [$2,370] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare part B deductible toward meeting the overall plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a copayment of up to [$20] for some office visits and up to a [$50] copayment for emergency room visits that do not result in an inpatient admission.

Note: We will not pay for services for which a charge is normally not made where there is no insurance. In addition, no benefits are payable for expenses incurred before the Coverage Effective Date.

Outline of Coverage Medicare Select Supplement

Premium Information
We can only raise your premium if we raise the premium for all policies like yours in this State. Your premiums will increase with age since this is an attained age policy.

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.

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.

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.

**High Deductible Plan G is available for effective dates on or after 01/01/2020.*

The South Dakota Service area includes the following counties: Aurora, Beadle, Bon Homme, Brookings, Brown, Brule, Buffalo, Campbell, Charles Mix, Clark, Clay, Codington, Corson, Davison, Day, Deuel, Dewey, Douglas, Edmunds, Faulk, Grant, Gregory, Hamlin, Hansen, Hutchinson, Jerauld, Kingsbury, Lake, Lincoln, Lyman, Marshall, McCook, McPherson, Miner, Minnehaha, Moody, Roberts, Sanborn, Spink, Tripp, Turner, Union, Walworth, and Yankton.

This Policy may not fully cover all of your medical costs. This includes medical expenses beyond those covered by Medicare.

This contract does not cover all skilled nursing home care expenses and does not cover custodial or residential nursing care. Read your contract carefully to determine which nursing home facilities and expenses are covered by your Policy.

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 & 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 applicable Standard Plans A, C, D, F, High Deductible F, G, High Deductible G*****, and N at any time.

Complete Answers Are Very Important
When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. Sanford Health Plan may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Medicare Select Provider Network 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.

When you purchase a Sanford Health Plan Select policy, you understand that benefits are paid when you seek planned care at a network hospital or ambulatory surgery center (ASC), unless you experience an emergency or specific services are not available at a network facilities and you have prior authorization from the Plan.

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

1. Services (other than outpatient surgery) are provided outside a hospital setting (i.e. in a physician's office or a skilled nursing facility); or

2. You 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 a Network facility; or

4. Services are not available at a Network facility.

Other than outpatient surgery as noted above, there are no restrictions on benefits for services received in a non-hospital or ASC setting beyond the standard limitations of Medicare supplement plans.

The Sanford Medicare Select Supplement Plan gives you the freedom to use traditional Medicare fee-for-service benefit when using facilities outside the plan's Select network. Please remember when you use this option; you are responsible or the Medicare deductibles, coinsurance, and any applicable copay amounts.

Non-Network Facility Admission Procedures
Prior to admission to a non-Network facility, you should, either directly or through your provider, contact Sanford Health Plan's Customer Service Department. A Customer Service Representative will confirm whether the required services are available from a network facility, and if not available, will assist you in locating a network facility that provides the necessary service. Utilizing Sanford Health Plan's Customer Service prior to use of a non-Network facility eliminates the need for retrospective inquiry as to the legitimacy of the filed claim.

NOTE: The Non-Network Facility Admission Procedures do not apply in emergency situations or while you are traveling outside the service area.

Quality Assurance
Sanford Health Plan ensures high quality health care 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, Medical Management, and 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.

We seek to provide quality administration and services to insured members of our Medicare Select supplement insurance plans and Network facilities.

Complaint & Grievance Procedures
If you are not fully satisfied with the administration, claims practices, or services we provide; or not fully satisfied with the services provided by a network facility, you may call us to express a complaint or write us to submit a grievance.
It is the policy of Sanford Health Plan to make reasonable efforts to resolve member complaints and grievances.

A process has been established for members (or their designees) to use when they are dissatisfied with the Plan, its network, or processes. Member notification of a complaint or grievance response will be made in writing or by telephone, which will also be logged for reference. For complaints and grievances related to the quality of care, the Plan will, at a minimum, state that the member's complaint or grievance was received and investigated.

If you have questions, are dissatisfied with the quality of Sanford Health Plan services, or have a problem regarding claims payment or your relationship with the Plan and its network facilities, contact us at the phone number and address shown on the back of your identification card.

Grievances, complaints, and/or appeals must be made **within 180 days** from the date the issue occurred.

Complaints While at a Network Facility
If, while receiving care at a network facility, you have a complaint regarding care from the facility, you may contact Customer Service at (800) 752-5863. Customer Service Representatives will work to resolve any issues you are experiencing, which may include relaying the complaint to the facility for prompt resolution.

Appeal Procedures
If you, or authorized representative acting on your behalf, disagree with the way an authorization for medical care has been made or with the Plan's decision to make payment on a claim, contact the Plan by calling or sending a letter to the following address:

Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110
Phone: (800) 752-5863 or TTY/TDD: (877) 652-1844
Fax: (605) 328-6812 (long distance charges may apply)

You have **180 days** from the date you receive a denial or notice of payment to appeal a decision made by the Plan.

Once the Plan has received a complete appeal, our goal is to make a decision and notify you in writing within sixty days. Any adverse decision notification will advise the member of the opportunity to submit written comments, documents or other information related to the appeal.

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 appeal. The Plan will document the substance of the appeal and any actions taken, including any aspects of clinical care involved. For appeals involving medical necessity, review will be done by a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment.

Medicare reconsideration process
If your complaint involves a dispute relating to the payment of services covered solely by Medicare, you must file a Medicare appeal through Medicare, not Sanford Health Plan. The steps to follow in filing a Medicare reconsideration are explained in the Explanation of Medicare Benefits that can be obtained from the Medicare.

Plan A Medicare (Part A) Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but $[1,484]	$0	$[1,484] (Part A deductible)
• 61st thru 90th day	All but $[371] a day	$[371] a day	$0
• 91st day and after:			
- While using 60 lifetime reserve days	All but $[742] a day	$[742] a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses[4]	$0
- Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	$0	$0
• 21st thru 100th day	All but $[185.50] a day	$0	Up to $[185.50] 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

[1, 4] **See page 26**

Plan A Medicare (Part B) Medicare Services – Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses In or Out of 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 $[203] of Medicare approved amounts[2] • Remainder of Medicare approved amounts	$0 Generally 80%	$0 Generally 20%[3]	$[203] (Part B deductible) $0
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
Blood • First 3 pints • Next $[203] of Medicare approved amounts[2] • Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0 $[203] (Part B deductible) $0
Clinical Laboratory Services Tests for Diagnostic Services	100%	$0	$0
Parts A & B			
Home Health Care Medicare Approved Services • Medically necessary skilled care services and medical supplies • Durable medical equipment – First $[203] of Medicare approved amounts[2] – Remainder of Medicare approved amounts	100% $0 80%	$0 $0 20%	$0 $[203] (Part B deductible) $0

[2, 3] **See page 26**

Plan C Medicare (Part A) Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but $[1,484]	$[1,484] (Part A deductible)	$0
• 61st thru 90th day	All but $[371] a day	$[371] a day	$0
• 91st day and after: - While using 60 lifetime reserve days	All but $[742] a day	$[742] a day	$0
• Once lifetime reserve days are used: - Additional 365 days	$0	100% of Medicare eligible expenses[4]	$0
- Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days • 21st thru 100th day • 101st day and after	All approved amounts All but $[185.50] a day $0	$0 Up to $[185.50] a day $0	$0 $0 All costs
Blood • First 3 pints • Additional amounts	$0 100%	3 pints $0	$0 $0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

[1, 4] **See page 26**

Plan C Medicare (Part B) Medicare Services – Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses In or Out of 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 $[203] of Medicare approved amounts[2] • Remainder of Medicare approved amounts	 $0 Generally 80%	 $[203] (Part B deductible) Generally 20%	 $0 $0
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
Blood • First 3 pints • Next $[203] of Medicare approved amounts[2] • Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $[203] (Part B deductible) 20%	 $0 $0 $0
Clinical Laboratory Services Tests for Diagnostic Services	100%	$0	$0
Parts A & B			
Home Health Care Medicare Approved Services • Medically necessary skilled care services and medical supplies • Durable medical equipment – First $[203] of Medicare approved amounts[2] – Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $[203] (Part B deductible) $0

[2, 3] **See page 26**

Plan C Medicare (Part B) Medicare Services – Per Calendar Year			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Other Benefits – Not Covered by Medicare			
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 – Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $[50,000]	 $[250] 20% and amounts over the $[50,000] lifetime maximum

Plan D Medicare (Part A) Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but $[1,484]	$[1,484] (Part A deductible)	$0
• 61st thru 90th day	All but $[371] a day	$[371] a day	$0
• 91st day and after:			
- While using 60 lifetime reserve days	All but $[742] a day	$[742] a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0[4]
- Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	$0	$0
• 21st thru 100th day	All but $[185.50] a day	Up to $[185.50] 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

[1] **See page 26**

Plan D Medicare (Part B) Medicare Services – Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses In or Out of 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 $[203] of Medicare approved amounts[2] • Remainder of Medicare approved amounts	 $0 Generally 80%	 $0 Generally 20%	 $[203] (Part B deductible) $0
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
Blood • First 3 pints • Next $[203] of Medicare approved amounts[2] • Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 $[203] (Part B deductible) $0
Clinical Laboratory Services Tests for Diagnostic Services	100%	$0	$0
Parts A & B			
Home Health Care Medicare Approved Services • Medically necessary skilled care services and medical supplies • Durable medical equipment – First $[203] of Medicare approved amounts[2] – Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $[203] (Part B deductible) $0

[2] **See page 26**

Plan D Medicare (Part B) Medicare Services – Per Calendar Year			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Other Benefits – Not Covered by Medicare			
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 – Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $[50,000]	 $[250] 20% and amounts over the $[50,000] lifetime maximum

Plan F or High Deductible Plan F Medicare (Part A) Hospital Services – Per Benefit Period

Services	Medicare Pays	After You Pay $[2,370] Deductible[5], Plan Pays	In Addition to $[2,370] Deductible[5], You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but $[1,484]	$[1,484] (Part A deductible)	$0
• 61st thru 90th day	All but $[371] a day	$[371] a day	$0
• 91st day and after:			
- While using 60 lifetime reserve days	All but $[742] a day	$[742] a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0[4]
- Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	$0	$0
• 21st thru 100th day	All but $[185.50] a day	Up to $[185.50] 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment /coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

[1, 4, 5] **See page 26**

Plan F or High Deductible Plan F Medicare (Part B) Medicare Services – Per Calendar Year

Services	Medicare Pays	After You Pay $[2,370] Deductible[5], Plan Pays	In Addition to $[2,370] Deductible[5], You Pay
Medical Expenses In or Out of 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 $[203] of Medicare approved amounts[2]	$0	$[203] (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 $[203] of Medicare approved amounts[2]	$0	$[203] (Part B deductible)	$0
• Remainder of Medicare approved amounts	80%	20%	$0
Clinical Laboratory Services Tests for Diagnostic Services	100%	$0	$0
Parts A & B			
Home Health Care Medicare Approved Services			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
– First $[203] of Medicare approved amounts[2]	$0	$[203] (Part B deductible)	$0
– Remainder of Medicare approved amounts	80%	20%	$0

[2, 5] See page 26

Plan F or High Deductible Plan F Medicare (Part B) Medicare Services – Per Calendar Year			
Services	**Medicare Pays**	**After You Pay $[2,370] Deductible[5], Plan Pays**	**In Addition to $[2,370] Deductible[5], You Pay**
Other Benefits – Not Covered by Medicare			
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 – Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $[50,000]	 $[250] 20% and amounts over the $[50,000] lifetime maximum

[5] **See page 26**

Plan G or High Deductible Plan G Medicare (Part A) Hospital Services – Per Benefit Period			
Services	**Medicare Pays**	**After You Pay $[2,370] Deductible[6], Plan Pays**	**In Addition to $[2,370] Deductible[6], You Pay**
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but $[1,484]	$[1,484] (Part A deductible)	$0
• 61st thru 90th day	All but $[371] a day	$[371] a day	$0
• 91st day and after: - While using 60 lifetime reserve days	All but $[742] a day	$[742] a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0[4]
- Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	$0	$0
• 21st thru 100th day	All but $[185.50] a day	Up to $[185.50] 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment /coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

[1,6] **See page 26**

Plan G or High Deductible Plan G Medicare (Part B) Medicare Services – Per Calendar Year			
Services	**Medicare Pays**	**After You Pay $[2,370] Deductible[6], Plan Pays**	**In Addition to $[2,370] Deductible[6],You Pay**
Medical Expenses In or Out of 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 $[203] of Medicare approved amounts[2] • Remainder of Medicare approved amounts	 $0 Generally 80%	 $0 Generally 20%	 $[203] (Part B deductible) $0
Part B Excess Charges (Above Medicare approved amounts)	$0	100%	$0
Blood • First 3 pints • Next $[203] of Medicare approved amounts[2] • Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 $[203] (Part B deductible) $0
Clinical Laboratory Services Tests for Diagnostic Services	100%	$0	$0
Parts A & B			
Home Health Care Medicare Approved Services • Medically necessary skilled care services and medical supplies • Durable medical equipment – First $[203] of Medicare approved amounts[2] – Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $[203] (Part B deductible) $0

[2, 6] **See page 26**

Plan G or High Deductible Plan G Medicare (Part B) Medicare Services – Per Calendar Year			
Services	**Medicare Pays**	**After You Pay $[2,370] Deductible[6], Plan Pays**	**In Addition to $[2,370] Deductible[6],You Pay**
Other Benefits – Not Covered by Medicare			
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 – Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $[50,000]	 $[250] 20% and amounts over the $[50,000] lifetime maximum

[6]See page 26

Plan N Medicare (Part A) Hospital Services – Per Benefit Period			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but $[1,484]	$[1,484] (Part A deductible)	$0
• 61st thru 90th day	All but $[371] a day	$[371] a day	$0
• 91st day and after: - While using 60 lifetime reserve days	All but $[742] a day	$[742] a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare eligible expenses	$0[4]
- Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	$0	$0
• 21st thru 100th day	All but $[185.50] a day	Up to $[185.50] 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

[1, 4] **See page 26**

Plan N Medicare (Part B) Medicare Services – Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses In or Out of 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 $[203] of Medicare approved amounts[2] • Remainder of Medicare approved amounts	$0 Generally 80%	$0 Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	$[203] (Part B deductible) Up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
Blood • First 3 pints • Next $[203] of Medicare approved amounts[2] • Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	0% $[203] (Part B deductible) $0
Clinical Laboratory Services Tests for Diagnostic Services	100%	$0	$0

[2] **See page 26**

Plan N Medicare (Part B) Medicare Services – Per Calendar Year			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Parts A & B			
Home Health Care Medicare Approved Services • Medically necessary skilled care services and medical supplies • Durable medical equipment – First $[203] of Medicare approved amounts[2] – Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $[203] (Part B deductible) $0
Other Benefits – Not Covered by Medicare			
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 – Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $[50,000]	 $[250] 20% and amounts over the $[50,000] lifetime maximum

[2] **See page 26**

Endnotes

[1]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.

[2]Once you have been billed $[203 in 2021] of Medicare Approved Amounts for covered services, your Part B Deductible will have been met for the calendar year.

[3]Part B Coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient services under a prospective payment system, applicable copay amounts.

[4] 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.

[5]This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[2,370 in 2021] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[2,370 in 2021]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy.

[6]This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2,370 in 2021] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [$2,370 in 2021]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

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.

Age	Plan A	Plan C[1]	Plan D	Plan F[1]	Plan F High Deductible[1]	Plan G	Plan G High Deductible[2]	Plan N
Under 65 Disabled	$111.61	$155.80	$148.12	$166.72	$75.02	$148.58	$62.40	$124.67
65 - 67	68.44	95.16	90.76	102.17	45.96	91.05	38.24	76.39
68	77.12	107.26	102.31	115.15	51.81	102.62	43.10	86.11
69	77.41	107.69	102.70	115.60	52.02	103.01	43.26	86.44
70	91.73	127.38	121.60	136.89	61.59	121.97	51.23	102.36
71	92.07	127.88	122.07	137.39	61.82	122.44	51.43	102.75
72	92.41	128.36	122.52	137.91	62.05	122.89	51.62	103.13
73	92.77	128.84	122.98	138.42	62.29	123.36	51.81	103.52
74	93.10	129.31	123.45	138.95	62.52	123.82	52.00	103.90
75	111.61	155.80	148.12	166.72	75.02	148.58	62.40	124.67
76	112.02	156.36	148.65	167.32	75.29	149.10	62.62	125.12
77	112.44	156.94	149.20	167.94	75.57	149.66	62.86	125.58
78	112.83	157.53	149.75	168.55	75.85	150.21	63.09	126.05

[1]Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.
[2]High deductible G is available for effective dates on or after 01/01/2020

Age	Plan A	Plan C[1]	Plan D	Plan F[1]	Plan F High Deductible[1]	Plan G	Plan G High Deductible[2]	Plan N
79	$113.24	$158.09	$150.29	$169.16	$76.12	$150.75	$63.31	$126.51
80	122.19	168.83	162.03	182.37	82.07	162.53	68.26	136.39
81	122.64	171.14	162.63	183.06	82.37	163.14	68.52	136.91
82	123.09	171.76	163.21	183.73	82.67	163.73	68.77	137.38
83	123.52	172.38	163.80	184.39	82.97	164.31	69.01	137.89
84	123.96	172.99	164.39	185.05	83.27	164.90	69.26	138.38
85 - 89	125.53	175.20	166.48	187.39	84.32	167.01	70.14	140.14
90 & Over	126.11	175.99	167.23	188.23	84.70	167.75	70.46	140.77

[1]Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.
[2]High deductible G is available for effective dates on or after 01/01/2020

Non-discrimination notice

Sanford Health Plan does not discriminate against any future, current, or past Member on the basis of race; ethnicity; color; national origin; disability; sex; gender; sexual orientation; gender identity; religion; spiritual beliefs; medical condition, including a current or past history of mental health and substance use disorders; sources of payment for care; or age, in its coverage, treatment, or benefit decisions.

Sanford Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, or other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Sanford Health Plan has failed to provide these services or discriminated in any way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator, 300 Cherapa Place #201, Sioux Falls, SD 57109, (877) 305-5463, TTY Number: (877) 652-1844, **shpcompliance@sanfordhealth.org.** You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Customer Service is available 8:00 AM to 5:00 PM CT Monday-Friday
Phone: (800) 752-5863 | TTY: (877) 652-1844
Free translation services are available at (800) 892-0675

Free help in other languages

For help in a language other than English, please call us toll-free at (800) 892-0675. Both oral and written translation services are available for free in at least 150 languages. If you have any questions, for example, about your benefits, this document, or how Sanford Health Plan pays for your care, please call us.

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-892-0675 (TTY: 1-877-652-1844).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-892-0675 (TTY: 1-877-652-1844).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-892-0675 (TTY: 1-877-652-1844).

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-892-0675 (TTY: 1-877-652-1844).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-892-0675 (TTY: 1-877-652-1844).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-892-1-800-892-0675 (TTY: 1-877-652-1844). 。

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-892-0675 (TTY: 1-877-652-1844).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-892-0675 (телетайп: 1-877-652-1844)

Laotian: : ໂປດຊາບ: ຖ ້ າວ ່ າທ ່ ານເວ ົ ້ າພາສາ ລາວ, ການບ ໍ ລ ິ ການຊ ່ ວຍເຫ ຼື ອດ ້ ານພາສາ, ໂດຍບ ໍ່ ເສ ັ ຽຄ ່ າ, ແມ ່ ນມ ີ ພ ້ ອມໃຫ ້ ທ ່ ານ. ໂທຣ 1-800-892-0675 (TTY: 1-877-652-1844).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية (رقم 1-877-652-1844

تتوافر لك بالمجان. اتصل برقم 1-800-892-0675 هاتف الصم والبكم

Karen:

[illegible] Sanford Health Plan [illegible] 1-800-892-0675 [illegible]

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-892-0675 (መስማት ለተሳናቸው: 1-877-652-1844).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무 료로 이용하실 수 있습니다. 1-800-892-0675 (TTY: 1-877-652-1844).번으로 전화해 주십시오.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-892-0675 (ATS : 1-877-652-1844).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-892-0675 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-877-652-1844).

Cambodian, Mon-Khmer:

[illegible] Sanford Health Plan [illegible]

1-800-892-0675

Notes

SANFORD
HEALTH PLAN

Customer Service
Toll-free: (800) 752-5863 | TTY/TDD: (877) 652-1844
For Free Help in a Language Other than English: (800) 892-0675

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