



**North Dakota [2021]**  
**Outline of Coverage for Medicare**  
**Supplement – MACRA**

**SANFORD**  
HEALTH PLAN

# North Dakota Outline of Coverage for Medicare 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 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 <sup>1</sup> | K <sup>2</sup>         | L <sup>2</sup>         | M   | N <sup>3</sup>                 | C  | F <sup>1</sup> |
| 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%                    | ✓   | ✓<br>copays apply <sup>3</sup> | ✓  | ✓              |
| 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] <sup>2</sup>   |                                   |   |   |                | [\$6,220] <sup>2</sup> | [\$3,110] <sup>2</sup> |     |                                |  |                |

 Indicates plans offered by Sanford Health Plan.

<sup>1</sup> 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.

<sup>2</sup> 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.

<sup>3</sup> 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 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.

The service area includes all counties in North Dakota.

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.

## **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.



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

| Services   | Medicare Pays   | Plan Pays   | You Pay   |
|--|---|---|---|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies <ul style="list-style-type: none"> <li>• First 60 days</li> <li>• 61<sup>st</sup> thru 90<sup>th</sup> day</li> <li>• 91<sup>st</sup> day and after:               <ul style="list-style-type: none"> <li>- While using 60 lifetime reserve days</li> </ul> </li> <li>• Once lifetime reserve days are used:               <ul style="list-style-type: none"> <li>- Additional 365 days</li> <li>- Beyond the additional 365 days</li> </ul> </li> </ul> | All but \$[1,484]<br><br>All but \$[371] a day<br><br>All but \$[742] a day<br><br>\$0<br><br>\$0 | \$0<br><br>\$[371] a day<br><br>\$[742] a day<br><br>100% of Medicare eligible expenses <sup>4</sup><br><br>\$0 | \$[1,484] (Part A deductible)<br><br>\$0<br><br>\$0<br><br>\$0<br><br>All costs |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>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 <ul style="list-style-type: none"> <li>• First 20 days</li> <li>• 21<sup>st</sup> thru 100<sup>th</sup> day</li> <li>• 101<sup>st</sup> day and after</li> </ul>   | All approved amounts<br>All but \$[185.50] a day<br>\$0   | \$0<br>\$0<br>\$0   | \$0<br>Up to \$[185.50] a day<br>All costs                                      |
| <b>Blood</b> <ul style="list-style-type: none"> <li>• First 3 pints</li> <li>• Additional amounts</li> </ul>   | \$0<br>100%   | 3 pints<br>\$0  | \$0<br>\$0  |
| <b>Hospice Care</b><br>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   |

<sup>1, 4</sup> See page 25



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

| Services   | Medicare Pays          | Plan Pays                         | You Pay                                       |
|--|------------------------|-----------------------------------|---|
| <b>Medical Expenses</b><br>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 <ul style="list-style-type: none"> <li>• First \$[203] of Medicare approved amounts<sup>2</sup></li> <li>• Remainder of Medicare approved amounts</li> </ul> | \$0<br>Generally 80%   | \$0<br>Generally 20% <sup>3</sup> | \$[203] (Part B deductible)<br>\$0            |
| <b>Part B Excess Charges</b><br>(Above Medicare approved amounts)  | \$0                    | \$0                               | All costs                                     |
| <b>Blood</b> <ul style="list-style-type: none"> <li>• First 3 pints</li> <li>• Next \$[203] of Medicare approved amounts<sup>2</sup></li> <li>• Remainder of Medicare approved amounts</li> </ul>  | \$0<br>\$0<br>80%      | All costs<br>\$0<br>20%           | \$0<br>\$[203] (Part B deductible)<br>\$0     |
| <b>Clinical Laboratory Services</b><br>Tests for Diagnostic Services   | 100%                   | \$0                               | \$0   |
| <b>Parts A &amp; B</b>   |                        |                                   |   |
| <b>Home Health Care</b><br>Medicare Approved Services <ul style="list-style-type: none"> <li>• Medically necessary skilled care services and medical supplies</li> <li>• Durable medical equipment                             <ul style="list-style-type: none"> <li>- First \$[203] of Medicare approved amounts<sup>2</sup></li> <li>- Remainder of Medicare approved amounts</li> </ul> </li> </ul>                      | 100%<br><br>\$0<br>80% | \$0<br><br>\$0<br>20%             | \$0<br><br>\$[203] (Part B deductible)<br>\$0 |

<sup>2, 3</sup> See page 25

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

| Services   | Medicare Pays   | Plan Pays   | You Pay   |
|--|---|---|---|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies <ul style="list-style-type: none"> <li>• First 60 days</li> <li>• 61<sup>st</sup> thru 90<sup>th</sup> day</li> <li>• 91<sup>st</sup> day and after:               <ul style="list-style-type: none"> <li>- While using 60 lifetime reserve days</li> </ul> </li> <li>• Once lifetime reserve days are used:               <ul style="list-style-type: none"> <li>- Additional 365 days</li> <li>- Beyond the additional 365 days</li> </ul> </li> </ul> | All but \$[1,484]<br><br>All but \$[371] a day<br><br>All but \$[742] a day<br><br>\$0<br><br>\$0 | \$[1,484] (Part A deductible)<br><br>\$[371] a day<br><br>\$[742] a day<br><br>100% of Medicare eligible expenses <sup>4</sup><br><br>\$0 | \$0<br><br>\$0<br><br>\$0<br><br>\$0<br><br>All costs |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>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 <ul style="list-style-type: none"> <li>• First 20 days</li> <li>• 21<sup>st</sup> thru 100<sup>th</sup> day</li> <li>• 101<sup>st</sup> day and after</li> </ul>   | All approved amounts All but \$[185.50] a day<br>\$0  | \$0<br>Up to \$[185.50] a day<br>\$0  | \$0<br>\$0<br>All costs                               |
| <b>Blood</b> <ul style="list-style-type: none"> <li>• First 3 pints</li> <li>• Additional amounts</li> </ul>   | \$0<br>100%   | 3 pints<br>\$0  | \$0<br>\$0  |
| <b>Hospice Care</b><br>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   |

<sup>1, 4</sup> See page 25

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

| Services   | Medicare Pays        | Plan Pays                                       | You Pay                                   |
|--|----------------------|---|---|
| <b>Medical Expenses</b><br>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 <ul style="list-style-type: none"> <li>• First \$[203] of Medicare approved amounts<sup>2</sup></li> <li>• Remainder of Medicare approved amounts</li> </ul> | \$0<br>Generally 80% | \$[203] (Part B deductible)<br>Generally 20%    | \$0<br>\$0                                |
| <b>Part B Excess Charges</b><br>(Above Medicare approved amounts)  | \$0                  | \$0   | All costs                                 |
| <b>Blood</b> <ul style="list-style-type: none"> <li>• First 3 pints</li> <li>• Next \$[203] of Medicare approved amounts<sup>2</sup></li> <li>• Remainder of Medicare approved amounts</li> </ul>  | \$0<br>\$0<br>80%    | All costs<br>\$[203] (Part B deductible)<br>20% | \$0<br>\$0<br>\$0                         |
| <b>Clinical Laboratory Services</b><br>Tests for Diagnostic Services   | 100%                 | \$0   | \$0                                       |
| <b>Parts A &amp; B</b>   |                      |   |   |
| <b>Home Health Care</b><br>Medicare Approved Services <ul style="list-style-type: none"> <li>• Medically necessary skilled care services and medical supplies</li> <li>• Durable medical equipment                             <ul style="list-style-type: none"> <li>- First \$[203] of Medicare approved amounts<sup>2</sup></li> <li>- Remainder of Medicare approved amounts</li> </ul> </li> </ul>                      | 100%<br>\$0<br>80%   | \$0<br>\$0<br>20%                               | \$0<br>\$[203] (Part B deductible)<br>\$0 |

<sup>2, 3</sup> See page 25

# Plan C

## Medicare (Part B) Medicare Services – Per Calendar Year

| Services   | Medicare Pays | Plan Pays  | You Pay   |
|--|---------------|--|---|
| <b>Other Benefits – Not Covered by Medicare</b>  |               |  |   |
| <b>Foreign Travel</b><br>Not covered by Medicare, medically necessary emergency care services <ul style="list-style-type: none"><li>• Beginning during the first 60 days of each trip outside the USA<ul style="list-style-type: none"><li>- First \$[250] each calendar year</li><li>- Remainder of charges</li></ul></li></ul> | \$0<br>\$0    | \$0<br>80% to a lifetime maximum benefit of \$[50,000] | \$[250]<br>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  |
|--|--|---|--|
| <p><b>Hospitalization<sup>1</sup></b><br/>Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <ul style="list-style-type: none"> <li>• First 60 days</li> <li>• 61<sup>st</sup> thru 90<sup>th</sup> day</li> <li>• 91<sup>st</sup> day and after: <ul style="list-style-type: none"> <li>- While using 60 lifetime reserve days</li> </ul> </li> <li>• Once lifetime reserve days are used: <ul style="list-style-type: none"> <li>- Additional 365 days</li> <li>- Beyond the additional 365 days</li> </ul> </li> </ul> | <p>All but \$[1,484]</p> <p>All but \$[371] a day</p> <p>All but \$[742] a day</p> <p>\$0</p> <p>\$0</p> | <p>\$[1,484] (Part A deductible)</p> <p>\$[371] a day</p> <p>\$[742] a day</p> <p>100% of Medicare eligible expenses</p> <p>\$0</p> | <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0<sup>4</sup></p> <p>All costs</p> |
| <p><b>Skilled Nursing Facility Care<sup>1</sup></b><br/>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</p> <ul style="list-style-type: none"> <li>• First 20 days</li> <li>• 21<sup>st</sup> thru 100<sup>th</sup> day</li> <li>• 101<sup>st</sup> day and after</li> </ul>   | <p>All approved amounts</p> <p>All but \$[185.50] a day</p> <p>\$0</p>                                   | <p>\$0</p> <p>Up to \$[185.50] a day</p> <p>\$0</p>   | <p>\$0</p> <p>\$0</p> <p>All costs</p>                                   |
| <p><b>Blood</b></p> <ul style="list-style-type: none"> <li>• First 3 pints</li> <li>• Additional amounts</li> </ul>  | <p>\$0</p> <p>100%</p>   | <p>3 pints</p> <p>\$0</p>   | <p>\$0</p> <p>\$0</p>  |
| <p><b>Hospice Care</b><br/>You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>  | <p>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</p>        | <p>Medicare copayment/coinsurance</p>   | <p>\$0</p>   |

<sup>1</sup> See page 25

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

| Services   | Medicare Pays              | Plan Pays                 | You Pay   |
|--|----------------------------|---------------------------|---|
| <b>Medical Expenses</b><br>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 <ul style="list-style-type: none"> <li>• First \$[203] of Medicare approved amounts<sup>2</sup></li> <li>• Remainder of Medicare approved amounts</li> </ul> | \$0<br>Generally 80%       | \$0<br>Generally 20%      | \$[203] (Part B deductible)<br>\$0                |
| <b>Part B Excess Charges</b><br>(Above Medicare approved amounts)  | \$0                        | \$0                       | All costs   |
| <b>Blood</b> <ul style="list-style-type: none"> <li>• First 3 pints</li> <li>• Next \$[203] of Medicare approved amounts<sup>2</sup></li> <li>• Remainder of Medicare approved amounts</li> </ul>  | \$0<br>\$0<br>80%          | All costs<br>\$0<br>20%   | \$0<br>\$[203] (Part B deductible)<br>\$0         |
| <b>Clinical Laboratory Services</b><br>Tests for Diagnostic Services   | 100%                       | \$0                       | \$0   |
| <b>Parts A &amp; B</b>   |                            |                           |   |
| <b>Home Health Care</b><br>Medicare Approved Services <ul style="list-style-type: none"> <li>• Medically necessary skilled care services and medical supplies</li> <li>• Durable medical equipment                             <ul style="list-style-type: none"> <li>- First \$[203] of Medicare approved amounts<sup>2</sup></li> <li>- Remainder of Medicare approved amounts</li> </ul> </li> </ul>                      | 100%<br><br>\$0<br><br>80% | \$0<br><br>\$0<br><br>20% | \$0<br><br>\$[203] (Part B deductible)<br><br>\$0 |

<sup>2</sup> See page 25

# Plan D

## Medicare (Part B) Medicare Services – Per Calendar Year

| Services   | Medicare Pays | Plan Pays  | You Pay   |
|--|---------------|--|---|
| <b>Other Benefits – Not Covered by Medicare</b>  |               |  |   |
| <b>Foreign Travel</b><br>Not covered by Medicare, medically necessary emergency care services <ul style="list-style-type: none"><li>• Beginning during the first 60 days of each trip outside the USA<ul style="list-style-type: none"><li>- First \$[250] each calendar year</li><li>- Remainder of charges</li></ul></li></ul> | \$0<br>\$0    | \$0<br>80% to a lifetime maximum benefit of \$[50,000] | \$[250]<br>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<br>\$[2,370] Deductible <sup>5</sup> ,<br>Plan Pays  | In Addition to \$[2,370]<br>Deductible <sup>5</sup> , You Pay      |
|--|---|--|--|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies <ul style="list-style-type: none"> <li>• First 60 days</li> <li>• 61st thru 90th day</li> <li>• 91<sup>st</sup> day and after:                             <ul style="list-style-type: none"> <li>- While using 60 lifetime reserve days</li> </ul> </li> <li>• Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>- Additional 365 days</li> <li>- Beyond the additional 365 days</li> </ul> </li> </ul> | All but \$[1,484]<br><br>All but \$[371] a day<br><br>All but \$[742] a day<br><br>\$0<br><br>\$0 | \$[1,484] (Part A deductible)<br><br>\$[371] a day<br><br>\$[742] a day<br><br>100% of Medicare eligible expenses<br><br>\$0 | \$0<br><br>\$0<br><br>\$0<br><br>\$0 <sup>4</sup><br><br>All costs |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>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 <ul style="list-style-type: none"> <li>• First 20 days</li> <li>• 21<sup>st</sup> thru 100th day</li> <li>• 101<sup>st</sup> day and after</li> </ul>  | All approved amounts<br>All but \$[185.50] a day<br>\$0   | \$0<br>Up to \$[185.50] a day<br>\$0   | \$0<br>\$0<br>All costs  |
| <b>Blood</b> <ul style="list-style-type: none"> <li>• First 3 pints</li> <li>• Additional amounts</li> </ul>   | \$0<br>100%   | 3 pints<br>\$0   | \$0<br>\$0   |
| <b>Hospice Care</b><br>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  |

<sup>1, 4, 5</sup> See page 25



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

| Services   | Medicare Pays        | After You Pay \$[2,370] Deductible <sup>5</sup> , Plan Pays | In Addition to \$[2,370] Deductible <sup>5</sup> , You Pay |
|--|----------------------|---|--|
| <b>Medical Expenses</b><br>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 <ul style="list-style-type: none"> <li>• First \$[203] of Medicare approved amounts<sup>2</sup></li> <li>• Remainder of Medicare approved amounts</li> </ul> | \$0<br>Generally 80% | \$[203] (Part B deductible)<br>Generally 20%                | \$0<br>\$0   |
| <b>Part B Excess Charges</b><br>(Above Medicare approved amounts)  | \$0                  | 100%  | \$0  |
| <b>Blood</b> <ul style="list-style-type: none"> <li>• First 3 pints</li> <li>• Next \$[203] of Medicare approved amounts<sup>2</sup></li> <li>• Remainder of Medicare approved amounts</li> </ul>  | \$0<br>\$0<br>80%    | All costs<br>\$[203] (Part B deductible)<br>20%             | \$0<br>\$0<br>\$0  |
| <b>Clinical Laboratory Services</b><br>Tests for Diagnostic Services   | 100%                 | \$0   | \$0  |
| <b>Parts A &amp; B</b>   |                      |   |  |
| <b>Home Health Care</b><br>Medicare Approved Services <ul style="list-style-type: none"> <li>• Medically necessary skilled care services and medical supplies</li> <li>• Durable medical equipment                             <ul style="list-style-type: none"> <li>- First \$[203] of Medicare approved amounts<sup>2</sup></li> <li>- Remainder of Medicare approved amounts</li> </ul> </li> </ul>                      | 100%<br>\$0<br>80%   | \$0<br>\$[203] (Part B deductible)<br>20%                   | \$0<br>\$0<br>\$0  |

<sup>2, 5</sup> See page 25

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

| Services   | Medicare Pays      | After You Pay \$[2,370] Deductible <sup>5</sup> , Plan Pays    | In Addition to \$[2,370] Deductible <sup>5</sup> , You Pay              |
|--|--------------------|--|---|
| <b>Other Benefits – Not Covered by Medicare</b>  |                    |  |   |
| <p><b>Foreign Travel</b><br/>                     Not covered by Medicare, medically necessary emergency care services</p> <ul style="list-style-type: none"> <li>• Beginning during the first 60 days of each trip outside the USA                             <ul style="list-style-type: none"> <li>- First \$[250] each calendar year</li> <li>- Remainder of charges</li> </ul> </li> </ul> | <p>\$0<br/>\$0</p> | <p>\$0<br/>80% to a lifetime maximum benefit of \$[50,000]</p> | <p>\$[250]<br/>20% and amounts over the \$[50,000] lifetime maximum</p> |

<sup>5</sup> See page 25

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

| Services   | Medicare Pays   | After You Pay \$[2,370] Deductible <sup>6</sup> , Plan Pays  | In Addition to \$[2,370] Deductible <sup>6</sup> , You Pay         |
|--|---|--|--|
| <b>Hospitalization<sup>1</sup></b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies <ul style="list-style-type: none"> <li>• First 60 days</li> <li>• 61<sup>st</sup> thru 90<sup>th</sup> day</li> <li>• 91<sup>st</sup> day and after:                             <ul style="list-style-type: none"> <li>- While using 60 lifetime reserve days</li> </ul> </li> <li>• Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>- Additional 365 days</li> <li>- Beyond the additional 365 days</li> </ul> </li> </ul> | All but \$[1,484]<br><br>All but \$[371] a day<br><br>All but \$[742] a day<br><br>\$0<br><br>\$0 | \$[1,484] (Part A deductible)<br><br>\$[371] a day<br><br>\$[742] a day<br><br>100% of Medicare eligible expenses<br><br>\$0 | \$0<br><br>\$0<br><br>\$0<br><br>\$0 <sup>4</sup><br><br>All costs |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>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 <ul style="list-style-type: none"> <li>• First 20 days</li> <li>• 21<sup>st</sup> thru 100<sup>th</sup> day</li> <li>• 101<sup>st</sup> day and after</li> </ul>   | All approved amounts<br>All but \$[185.50] a day<br>\$0   | \$0<br>Up to \$[185.50] a day<br>\$0   | \$0<br>\$0<br>All costs  |
| <b>Blood</b> <ul style="list-style-type: none"> <li>• First 3 pints</li> <li>• Additional amounts</li> </ul>   | \$0<br>100%   | 3 pints<br>\$0   | \$0<br>\$0   |
| <b>Hospice Care</b><br>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  |

<sup>1,6</sup> See page 25

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

| Services   | Medicare Pays          | After You Pay \$[2,370] Deductible <sup>6</sup> , Plan Pays | In Addition to \$[2,370] Deductible <sup>6</sup> , You Pay |
|--|------------------------|---|--|
| <b>Medical Expenses</b><br>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 <ul style="list-style-type: none"> <li>• First \$[203] of Medicare approved amounts<sup>2</sup></li> <li>• Remainder of Medicare approved amounts</li> </ul> | \$0<br>Generally 80%   | \$0<br>Generally 20%  | \$[203] (Part B deductible)<br>\$0                         |
| <b>Part B Excess Charges</b><br>(Above Medicare approved amounts)  | \$0                    | 100%  | \$0  |
| <b>Blood</b> <ul style="list-style-type: none"> <li>• First 3 pints</li> <li>• Next \$[203] of Medicare approved amounts<sup>2</sup></li> <li>• Remainder of Medicare approved amounts</li> </ul>  | \$0<br>\$0 80%         | All costs<br>\$0 20%  | \$0<br>\$[203] (Part B deductible)<br>\$0                  |
| <b>Clinical Laboratory Services</b><br>Tests for Diagnostic Services   | 100%                   | \$0   | \$0  |
| <b>Parts A &amp; B</b>   |                        |   |  |
| <b>Home Health Care</b><br>Medicare Approved Services <ul style="list-style-type: none"> <li>• Medically necessary skilled care services and medical supplies</li> <li>• Durable medical equipment                             <ul style="list-style-type: none"> <li>- First \$[203] of Medicare approved amounts<sup>2</sup></li> <li>- Remainder of Medicare approved amounts</li> </ul> </li> </ul>                      | 100%<br><br>\$0<br>80% | \$0<br><br>\$0<br>20%                                       | \$0<br><br>\$[203] (Part B deductible)<br>\$0              |

<sup>2, 6</sup> See page 25

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

| Services   | Medicare Pays      | After You Pay \$[2,370] Deductible <sup>6</sup> , Plan Pays    | In Addition to \$[2,370] Deductible <sup>6</sup> , You Pay              |
|--|--------------------|--|---|
| <b>Other Benefits – Not Covered by Medicare</b>  |                    |  |   |
| <p><b>Foreign Travel</b><br/>                     Not covered by Medicare, medically necessary emergency care services</p> <ul style="list-style-type: none"> <li>• Beginning during the first 60 days of each trip outside the USA                             <ul style="list-style-type: none"> <li>- First \$[250] each calendar year</li> <li>- Remainder of charges</li> </ul> </li> </ul> | <p>\$0<br/>\$0</p> | <p>\$0<br/>80% to a lifetime maximum benefit of \$[50,000]</p> | <p>\$[250]<br/>20% and amounts over the \$[50,000] lifetime maximum</p> |

<sup>6</sup>See page 25

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

| Services   | Medicare Pays  | Plan Pays   | You Pay  |
|--|--|---|--|
| <p><b>Hospitalization<sup>1</sup></b><br/>Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <ul style="list-style-type: none"> <li>• First 60 days</li> <li>• 61<sup>st</sup> thru 90<sup>th</sup> day</li> <li>• 91<sup>st</sup> day and after: <ul style="list-style-type: none"> <li>- While using 60 lifetime reserve days</li> </ul> </li> <li>• Once lifetime reserve days are used: <ul style="list-style-type: none"> <li>- Additional 365 days</li> <li>- Beyond the additional 365 days</li> </ul> </li> </ul> | <p>All but \$[1,484]</p> <p>All but \$[371] a day</p> <p>All but \$[742] a day</p> <p>\$0</p> <p>\$0</p> | <p>\$[1,484] (Part A deductible)</p> <p>\$[371] a day</p> <p>\$[742] a day</p> <p>100% of Medicare eligible expenses</p> <p>\$0</p> | <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0<sup>4</sup></p> <p>All costs</p> |
| <p><b>Skilled Nursing Facility Care<sup>1</sup></b><br/>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</p> <ul style="list-style-type: none"> <li>• First 20 days</li> <li>• 21<sup>st</sup> thru 100<sup>th</sup> day</li> <li>• 101<sup>st</sup> day and after</li> </ul>   | <p>All approved amounts</p> <p>All but \$[185.50] a day</p> <p>\$0</p>                                   | <p>\$0</p> <p>Up to \$[185.50] a day</p> <p>\$0</p>   | <p>\$0</p> <p>\$0</p> <p>All costs</p>                                   |
| <p><b>Blood</b></p> <ul style="list-style-type: none"> <li>• First 3 pints</li> <li>• Additional amounts</li> </ul>  | <p>\$0</p> <p>100%</p>   | <p>3 pints</p> <p>\$0</p>   | <p>\$0</p> <p>\$0</p>  |
| <p><b>Hospice Care</b><br/>You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>  | <p>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</p>        | <p>Medicare copayment/coinsurance</p>   | <p>\$0</p>   |

<sup>1,4</sup> See page 25

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

| Services   | Medicare Pays                | Plan Pays   | You Pay   |
|--|------------------------------|---|---|
| <p><b>Medical Expenses</b><br/>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</p> <ul style="list-style-type: none"> <li>• First \$[203] of Medicare approved amounts<sup>2</sup></li> <li>• Remainder of Medicare approved amounts</li> </ul> | <p>\$0<br/>Generally 80%</p> | <p>\$0<br/>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.</p> | <p>\$[203] (Part B deductible)<br/>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.</p> |
| <p><b>Part B Excess Charges</b><br/>(Above Medicare approved amounts)</p>  | <p>\$0</p>                   | <p>\$0</p>  | <p>All costs</p>  |
| <p><b>Blood</b></p> <ul style="list-style-type: none"> <li>• First 3 pints</li> <li>• Next \$[203] of Medicare approved amounts<sup>2</sup></li> <li>• Remainder of Medicare approved amounts</li> </ul>   | <p>\$0<br/>\$0<br/>80%</p>   | <p>All costs<br/>\$0<br/>20%</p>  | <p>0%<br/>\$[203] (Part B deductible)<br/>\$0</p>   |
| <p><b>Clinical Laboratory Services</b><br/>Tests for Diagnostic Services</p>   | <p>100%</p>                  | <p>\$0</p>  | <p>\$0</p>  |

<sup>2</sup> See page 25

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

| Services  | Medicare Pays | Plan Pays  | You Pay   |
|---|---------------|--|---|
| <b>Parts A &amp; B</b>  |               |  |   |
| <b>Home Health Care</b>   |               |  |   |
| Medicare Approved Services  |               |  |   |
| <ul style="list-style-type: none"> <li>Medically necessary skilled care services and medical supplies</li> </ul>  | 100%          | \$0  | \$0   |
| <ul style="list-style-type: none"> <li>Durable medical equipment                             <ul style="list-style-type: none"> <li>First \$[203] of Medicare approved amounts<sup>2</sup></li> <li>Remainder of Medicare approved amounts</li> </ul> </li> </ul> | \$0<br>80%    | \$0<br>20%   | \$[203] (Part B deductible)<br>\$0                              |
| <b>Other Benefits – Not Covered by Medicare</b>   |               |  |   |
| <b>Foreign Travel</b>   |               |  |   |
| Not covered by Medicare, medically necessary emergency care services  |               |  |   |
| <ul style="list-style-type: none"> <li>Beginning during the first 60 days of each trip outside the USA                             <ul style="list-style-type: none"> <li>First \$[250] each calendar year</li> <li>Remainder of charges</li> </ul> </li> </ul>   | \$0<br>\$0    | \$0<br>80% to a lifetime maximum benefit of \$[50,000] | \$[250]<br>20% and amounts over the \$[50,000] lifetime maximum |

<sup>2</sup> See page 25



# Endnotes

<sup>1</sup>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.

<sup>2</sup>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.

<sup>3</sup>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.

<sup>4</sup>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.

<sup>5</sup>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.

<sup>6</sup>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 – Non-Tobacco Plans A, C, D

Your premium is based on your age, gender, 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 <sup>1</sup> |          | Plan D   |          |
|-----|----------|----------|---------------------|----------|----------|----------|
|     | Male     | Female   | Male                | Female   | Male     | Female   |
| 65  | \$81.72  | \$80.75  | \$152.19            | \$150.40 | \$138.09 | \$136.59 |
| 66  | \$83.29  | \$82.32  | \$155.12            | \$153.34 | \$140.75 | \$139.26 |
| 67  | \$84.89  | \$83.90  | \$158.10            | \$156.27 | \$143.45 | \$141.92 |
| 68  | \$90.67  | \$87.67  | \$168.85            | \$163.30 | \$153.21 | \$148.30 |
| 69  | \$96.52  | \$91.63  | \$179.75            | \$170.68 | \$163.10 | \$155.00 |
| 70  | \$102.41 | \$95.70  | \$190.73            | \$178.26 | \$173.06 | \$161.89 |
| 71  | \$108.36 | \$99.73  | \$201.80            | \$185.75 | \$183.11 | \$168.70 |
| 72  | \$114.44 | \$103.79 | \$213.12            | \$193.33 | \$193.38 | \$175.57 |
| 73  | \$119.61 | \$107.73 | \$222.76            | \$200.66 | \$202.13 | \$182.24 |
| 74  | \$124.84 | \$111.62 | \$232.48            | \$207.90 | \$210.95 | \$188.81 |
| 75  | \$130.10 | \$115.62 | \$242.29            | \$215.35 | \$219.85 | \$195.58 |
| 76  | \$134.89 | \$119.20 | \$251.21            | \$222.02 | \$227.94 | \$201.63 |
| 77  | \$139.68 | \$122.71 | \$260.13            | \$228.56 | \$236.04 | \$207.57 |
| 78  | \$143.45 | \$125.42 | \$267.16            | \$233.61 | \$242.41 | \$212.16 |
| 79  | \$147.24 | \$128.06 | \$274.20            | \$238.53 | \$248.81 | \$216.63 |
| 80  | \$151.03 | \$130.71 | \$281.26            | \$243.47 | \$255.21 | \$221.11 |

<sup>1</sup>Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

# Monthly Premium Information – Non-Tobacco Plans A, C, D (cont.)

Your premium is based on your age, gender, 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 <sup>1</sup> |          | Plan D   |          |
|------|----------|----------|---------------------|----------|----------|----------|
|      | Male     | Female   | Male                | Female   | Male     | Female   |
| 81   | \$154.83 | \$133.36 | \$288.34            | \$248.40 | \$261.63 | \$225.59 |
| 82   | \$158.63 | \$136.02 | \$295.42            | \$253.37 | \$268.06 | \$230.10 |
| 83   | \$161.97 | \$138.30 | \$301.64            | \$257.60 | \$273.71 | \$233.94 |
| 84   | \$165.40 | \$140.65 | \$308.02            | \$261.97 | \$279.49 | \$237.92 |
| 85   | \$168.76 | \$142.93 | \$314.27            | \$266.22 | \$285.17 | \$241.78 |
| 86   | \$171.80 | \$144.93 | \$319.94            | \$269.96 | \$290.31 | \$245.17 |
| 87   | \$174.83 | \$146.95 | \$325.59            | \$273.71 | \$295.43 | \$248.58 |
| 88   | \$176.51 | \$148.64 | \$328.71            | \$276.86 | \$298.27 | \$251.44 |
| 89   | \$178.10 | \$150.24 | \$331.68            | \$279.85 | \$300.97 | \$254.15 |
| 90   | \$179.78 | \$151.85 | \$334.81            | \$282.84 | \$303.80 | \$256.87 |
| 91   | \$181.45 | \$153.45 | \$337.92            | \$285.83 | \$306.63 | \$259.58 |
| 92   | \$183.12 | \$155.14 | \$341.03            | \$288.97 | \$309.45 | \$262.44 |
| 93   | \$184.64 | \$156.66 | \$343.86            | \$291.79 | \$312.01 | \$265.00 |
| 94   | \$186.23 | \$158.18 | \$346.82            | \$294.64 | \$314.70 | \$267.58 |
| 95   | \$187.75 | \$159.71 | \$349.64            | \$297.48 | \$317.26 | \$270.16 |
| 96   | \$189.34 | \$161.22 | \$352.60            | \$300.30 | \$319.95 | \$272.73 |
| 97   | \$190.85 | \$162.74 | \$355.41            | \$303.13 | \$322.50 | \$275.30 |
| 98   | \$192.44 | \$164.26 | \$358.38            | \$305.96 | \$325.19 | \$277.86 |
| 99   | \$194.03 | \$165.78 | \$361.33            | \$308.79 | \$327.87 | \$280.44 |
| 100+ | \$194.03 | \$165.78 | \$361.33            | \$308.79 | \$327.87 | \$280.44 |

<sup>1</sup>Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

# Monthly Premium Information – Non-Tobacco Plans F, F-HD, G, G-HD, N

Your premium is based on your age, gender, 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 F <sup>1</sup> |          | Plan F High Deductible <sup>1</sup> |          | Plan G   |          | Plan G High Deductible <sup>2</sup> |         | Plan N   |          |
|-----|---------------------|----------|-------------------------------------|----------|----------|----------|-------------------------------------|---------|----------|----------|
|     | Male                | Female   | Male                                | Female   | Male     | Female   | Male                                | Female  | Male     | Female   |
| 65  | \$155.43            | \$153.74 | \$74.28                             | \$73.47  | \$122.79 | \$121.46 | \$51.57                             | \$51.01 | \$116.23 | \$114.97 |
| 66  | \$158.43            | \$156.75 | \$75.71                             | \$74.91  | \$125.16 | \$123.83 | \$52.57                             | \$52.01 | \$118.47 | \$117.22 |
| 67  | \$161.47            | \$159.74 | \$77.17                             | \$76.34  | \$127.56 | \$126.19 | \$53.58                             | \$53.00 | \$120.75 | \$119.45 |
| 68  | \$172.45            | \$166.93 | \$82.41                             | \$79.77  | \$136.23 | \$131.87 | \$57.22                             | \$55.39 | \$128.96 | \$124.83 |
| 69  | \$183.58            | \$174.47 | \$87.73                             | \$83.37  | \$145.03 | \$137.83 | \$60.91                             | \$57.89 | \$137.28 | \$130.47 |
| 70  | \$194.79            | \$182.22 | \$93.09                             | \$87.08  | \$153.89 | \$143.95 | \$64.63                             | \$60.46 | \$145.67 | \$136.26 |
| 71  | \$206.11            | \$189.88 | \$98.50                             | \$90.74  | \$162.82 | \$150.01 | \$68.39                             | \$63.00 | \$154.13 | \$141.99 |
| 72  | \$217.66            | \$197.62 | \$104.02                            | \$94.44  | \$171.95 | \$156.12 | \$72.22                             | \$65.57 | \$162.77 | \$147.78 |
| 73  | \$227.51            | \$205.12 | \$108.73                            | \$98.02  | \$179.73 | \$162.04 | \$75.49                             | \$68.06 | \$170.13 | \$153.39 |
| 74  | \$237.44            | \$212.52 | \$113.47                            | \$101.56 | \$187.58 | \$167.89 | \$78.78                             | \$70.51 | \$177.56 | \$158.93 |
| 75  | \$247.46            | \$220.13 | \$118.26                            | \$105.20 | \$195.49 | \$173.91 | \$82.11                             | \$73.04 | \$185.05 | \$164.62 |
| 76  | \$256.57            | \$226.95 | \$122.61                            | \$108.45 | \$202.69 | \$179.29 | \$85.13                             | \$75.30 | \$191.86 | \$169.72 |
| 77  | \$265.68            | \$233.64 | \$126.97                            | \$111.65 | \$209.89 | \$184.57 | \$88.15                             | \$77.52 | \$198.68 | \$174.72 |
| 78  | \$272.85            | \$238.80 | \$130.40                            | \$114.12 | \$215.55 | \$188.65 | \$90.53                             | \$79.23 | \$204.04 | \$178.58 |
| 79  | \$280.05            | \$243.83 | \$133.84                            | \$116.52 | \$221.24 | \$192.63 | \$92.92                             | \$80.90 | \$209.42 | \$182.34 |
| 80  | \$287.26            | \$248.88 | \$137.28                            | \$118.93 | \$226.94 | \$196.61 | \$95.31                             | \$82.58 | \$214.82 | \$186.11 |

<sup>1</sup>Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

<sup>2</sup>High deductible G is available for effective dates on or after 01/01/2020

# Monthly Premium Information – Non-Tobacco Plans F, F-HD, G, G-HD, N (cont.)

Your premium is based on your age, gender, 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 F <sup>1</sup> |          | Plan F High Deductible <sup>1</sup> |          | Plan G   |          | Plan G High Deductible <sup>2</sup> |          | Plan N   |          |
|------|---------------------|----------|-------------------------------------|----------|----------|----------|-------------------------------------|----------|----------|----------|
|      | Male                | Female   | Male                                | Female   | Male     | Female   | Male                                | Female   | Male     | Female   |
| 81   | \$294.49            | \$253.92 | \$140.73                            | \$121.34 | \$232.64 | \$200.60 | \$97.71                             | \$84.25  | \$220.22 | \$189.88 |
| 82   | \$301.73            | \$258.99 | \$144.19                            | \$123.77 | \$238.36 | \$204.60 | \$100.11                            | \$85.93  | \$225.63 | \$193.68 |
| 83   | \$308.08            | \$263.32 | \$147.23                            | \$125.83 | \$243.38 | \$208.02 | \$102.22                            | \$87.37  | \$230.38 | \$196.91 |
| 84   | \$314.59            | \$267.79 | \$150.34                            | \$127.97 | \$248.53 | \$211.56 | \$104.38                            | \$88.85  | \$235.25 | \$200.26 |
| 85   | \$320.98            | \$272.14 | \$153.39                            | \$130.05 | \$253.57 | \$214.99 | \$106.50                            | \$90.29  | \$240.03 | \$203.51 |
| 86   | \$326.76            | \$275.96 | \$156.16                            | \$131.87 | \$258.14 | \$218.01 | \$108.42                            | \$91.56  | \$244.36 | \$206.36 |
| 87   | \$332.53            | \$279.79 | \$158.92                            | \$133.70 | \$262.70 | \$221.03 | \$110.33                            | \$92.83  | \$248.67 | \$209.23 |
| 88   | \$335.73            | \$283.01 | \$160.44                            | \$135.24 | \$265.22 | \$223.58 | \$111.39                            | \$93.90  | \$251.06 | \$211.64 |
| 89   | \$338.76            | \$286.06 | \$161.89                            | \$136.70 | \$267.62 | \$225.99 | \$112.40                            | \$94.92  | \$253.33 | \$213.92 |
| 90   | \$341.95            | \$289.13 | \$163.42                            | \$138.17 | \$270.14 | \$228.41 | \$113.46                            | \$95.93  | \$255.71 | \$216.21 |
| 91   | \$345.13            | \$292.18 | \$164.94                            | \$139.62 | \$272.65 | \$230.82 | \$114.51                            | \$96.94  | \$258.09 | \$218.49 |
| 92   | \$348.31            | \$295.39 | \$166.46                            | \$141.16 | \$275.16 | \$233.36 | \$115.57                            | \$98.01  | \$260.47 | \$220.90 |
| 93   | \$351.19            | \$298.27 | \$167.83                            | \$142.54 | \$277.44 | \$235.64 | \$116.53                            | \$98.97  | \$262.63 | \$223.05 |
| 94   | \$354.22            | \$301.18 | \$169.28                            | \$143.93 | \$279.83 | \$237.93 | \$117.53                            | \$99.93  | \$264.89 | \$225.23 |
| 95   | \$357.10            | \$304.08 | \$170.66                            | \$145.31 | \$282.11 | \$240.23 | \$118.49                            | \$100.90 | \$267.04 | \$227.40 |
| 96   | \$360.12            | \$306.98 | \$172.10                            | \$146.70 | \$284.50 | \$242.51 | \$119.49                            | \$101.85 | \$269.30 | \$229.56 |
| 97   | \$362.99            | \$309.86 | \$173.47                            | \$148.08 | \$286.76 | \$244.79 | \$120.44                            | \$102.81 | \$271.45 | \$231.72 |
| 98   | \$366.02            | \$312.75 | \$174.92                            | \$149.46 | \$289.16 | \$247.07 | \$121.45                            | \$103.77 | \$273.72 | \$233.88 |
| 99   | \$369.04            | \$315.65 | \$176.36                            | \$150.84 | \$291.54 | \$249.36 | \$122.45                            | \$104.73 | \$275.97 | \$236.05 |
| 100+ | \$369.04            | \$315.65 | \$176.36                            | \$150.84 | \$291.54 | \$249.36 | \$122.45                            | \$104.73 | \$275.97 | \$236.05 |

<sup>1</sup>Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

<sup>2</sup>High deductible G is available for effective dates on or after 01/01/2020

# Monthly Premium Information –Tobacco User Rates

## Plans A, C, D

Your premium is based on your age, gender, 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 <sup>1</sup> |          | Plan D   |          |
|-----|----------|----------|---------------------|----------|----------|----------|
|     | Male     | Female   | Male                | Female   | Male     | Female   |
| 65  | \$98.06  | \$96.89  | \$182.62            | \$180.48 | \$165.71 | \$163.91 |
| 66  | \$99.95  | \$98.79  | \$186.14            | \$184.01 | \$168.90 | \$167.11 |
| 67  | \$101.87 | \$100.67 | \$189.72            | \$187.52 | \$172.15 | \$170.30 |
| 68  | \$108.80 | \$105.21 | \$202.62            | \$195.96 | \$183.85 | \$177.97 |
| 69  | \$115.82 | \$109.96 | \$215.69            | \$204.81 | \$195.72 | \$186.00 |
| 70  | \$122.90 | \$114.84 | \$228.87            | \$213.91 | \$207.68 | \$194.27 |
| 71  | \$130.03 | \$119.67 | \$242.16            | \$222.90 | \$219.74 | \$202.44 |
| 72  | \$137.32 | \$124.55 | \$255.74            | \$231.99 | \$232.05 | \$210.69 |
| 73  | \$143.54 | \$129.28 | \$267.31            | \$240.80 | \$242.55 | \$218.68 |
| 74  | \$149.80 | \$133.94 | \$278.98            | \$249.48 | \$253.14 | \$226.57 |
| 75  | \$156.12 | \$138.74 | \$290.75            | \$258.42 | \$263.82 | \$234.69 |
| 76  | \$161.87 | \$143.03 | \$301.45            | \$266.42 | \$273.53 | \$241.96 |
| 77  | \$167.62 | \$147.25 | \$312.16            | \$274.27 | \$283.25 | \$249.09 |
| 78  | \$172.15 | \$150.50 | \$320.59            | \$280.34 | \$290.90 | \$254.59 |
| 79  | \$176.69 | \$153.67 | \$329.04            | \$286.24 | \$298.57 | \$259.96 |
| 80  | \$181.24 | \$156.86 | \$337.51            | \$292.17 | \$306.26 | \$265.34 |

<sup>1</sup>Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

# Monthly Premium Information – Tobacco User Rates

## Plans A, C, D (cont.)

Your premium is based on your age, gender, 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 <sup>1</sup> |          | Plan D   |          |
|------|----------|----------|---------------------|----------|----------|----------|
|      | Male     | Female   | Male                | Female   | Male     | Female   |
| 81   | \$185.79 | \$160.03 | \$346.00            | \$298.08 | \$313.96 | \$270.71 |
| 82   | \$190.36 | \$163.23 | \$354.51            | \$304.04 | \$321.68 | \$276.12 |
| 83   | \$194.37 | \$165.96 | \$361.97            | \$309.12 | \$328.45 | \$280.73 |
| 84   | \$198.48 | \$168.78 | \$369.62            | \$314.37 | \$335.39 | \$285.50 |
| 85   | \$202.51 | \$171.51 | \$377.13            | \$319.47 | \$342.20 | \$290.13 |
| 86   | \$206.16 | \$173.92 | \$383.92            | \$323.95 | \$348.37 | \$294.21 |
| 87   | \$209.80 | \$176.34 | \$390.70            | \$328.45 | \$354.52 | \$298.29 |
| 88   | \$211.81 | \$178.37 | \$394.46            | \$332.23 | \$357.93 | \$301.72 |
| 89   | \$213.72 | \$180.29 | \$398.02            | \$335.82 | \$361.16 | \$304.98 |
| 90   | \$215.74 | \$182.22 | \$401.77            | \$339.41 | \$364.56 | \$308.25 |
| 91   | \$217.75 | \$184.14 | \$405.51            | \$343.00 | \$367.95 | \$311.50 |
| 92   | \$219.75 | \$186.17 | \$409.24            | \$346.77 | \$371.34 | \$314.92 |
| 93   | \$221.57 | \$187.99 | \$412.63            | \$350.15 | \$374.42 | \$318.00 |
| 94   | \$223.48 | \$189.82 | \$416.18            | \$353.56 | \$377.64 | \$321.10 |
| 95   | \$225.30 | \$191.65 | \$419.57            | \$356.97 | \$380.72 | \$324.19 |
| 96   | \$227.20 | \$193.47 | \$423.12            | \$360.37 | \$383.94 | \$327.27 |
| 97   | \$229.02 | \$195.29 | \$426.50            | \$363.76 | \$387.00 | \$330.35 |
| 98   | \$230.93 | \$197.11 | \$430.06            | \$367.15 | \$390.23 | \$333.43 |
| 99   | \$232.83 | \$198.94 | \$433.60            | \$370.55 | \$393.45 | \$336.52 |
| 100+ | \$232.83 | \$198.94 | \$433.60            | \$370.55 | \$393.45 | \$336.52 |

<sup>1</sup>Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

# Monthly Premium Information – Tobacco User Rates

## Plans F, F-HD, G, G-HD, N

Your premium is based on your age, gender, 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 F <sup>1</sup> |          | Plan F High Deductible <sup>1</sup> |          | Plan G   |          | Plan G High Deductible <sup>2</sup> |         | Plan N   |          |
|-----|---------------------|----------|-------------------------------------|----------|----------|----------|-------------------------------------|---------|----------|----------|
|     | Male                | Female   | Male                                | Female   | Male     | Female   | Male                                | Female  | Male     | Female   |
| 65  | \$186.52            | \$184.49 | \$89.14                             | \$88.16  | \$147.35 | \$145.75 | \$61.89                             | \$61.21 | \$139.48 | \$137.96 |
| 66  | \$190.11            | \$188.10 | \$90.85                             | \$89.89  | \$150.19 | \$148.60 | \$63.08                             | \$62.41 | \$142.17 | \$140.66 |
| 67  | \$193.76            | \$191.69 | \$92.60                             | \$91.60  | \$153.07 | \$151.43 | \$64.29                             | \$63.60 | \$144.90 | \$143.35 |
| 68  | \$206.94            | \$200.31 | \$98.90                             | \$95.72  | \$163.48 | \$158.25 | \$68.66                             | \$66.46 | \$154.75 | \$149.80 |
| 69  | \$220.29            | \$209.36 | \$105.28                            | \$100.05 | \$174.03 | \$165.40 | \$73.09                             | \$69.47 | \$164.74 | \$156.56 |
| 70  | \$233.75            | \$218.66 | \$111.71                            | \$104.49 | \$184.67 | \$172.74 | \$77.56                             | \$72.55 | \$174.80 | \$163.52 |
| 71  | \$247.33            | \$227.86 | \$118.20                            | \$108.89 | \$195.39 | \$180.01 | \$82.06                             | \$75.60 | \$184.95 | \$170.39 |
| 72  | \$261.19            | \$237.15 | \$124.82                            | \$113.33 | \$206.34 | \$187.34 | \$86.66                             | \$78.68 | \$195.32 | \$177.34 |
| 73  | \$273.01            | \$246.14 | \$130.47                            | \$117.63 | \$215.68 | \$194.45 | \$90.58                             | \$81.67 | \$204.16 | \$184.07 |
| 74  | \$284.93            | \$255.02 | \$136.17                            | \$121.87 | \$225.09 | \$201.47 | \$94.54                             | \$84.62 | \$213.07 | \$190.71 |
| 75  | \$296.95            | \$264.16 | \$141.91                            | \$126.24 | \$234.59 | \$208.69 | \$98.53                             | \$87.65 | \$222.06 | \$197.54 |
| 76  | \$307.88            | \$272.34 | \$147.13                            | \$130.14 | \$243.22 | \$215.15 | \$102.15                            | \$90.36 | \$230.23 | \$203.66 |
| 77  | \$318.82            | \$280.37 | \$152.36                            | \$133.98 | \$251.87 | \$221.49 | \$105.78                            | \$93.03 | \$238.42 | \$209.66 |
| 78  | \$327.42            | \$286.56 | \$156.48                            | \$136.94 | \$258.67 | \$226.39 | \$108.64                            | \$95.08 | \$244.85 | \$214.30 |
| 79  | \$336.06            | \$292.60 | \$160.60                            | \$139.83 | \$265.49 | \$231.15 | \$111.51                            | \$97.08 | \$251.31 | \$218.81 |
| 80  | \$344.71            | \$298.66 | \$164.74                            | \$142.72 | \$272.32 | \$235.94 | \$114.38                            | \$99.09 | \$257.78 | \$223.34 |

<sup>1</sup>Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

<sup>2</sup>High deductible G is available for effective dates on or after 01/01/2020



# Monthly Premium Information – Tobacco User Rates

## Plans F, F-HD, G, G-HD, N (cont.)

Your premium is based on your age, gender, 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 F <sup>1</sup> |          | Plan F High Deductible <sup>1</sup> |          | Plan G   |          | Plan G High Deductible <sup>2</sup> |          | Plan N   |          |
|------|---------------------|----------|-------------------------------------|----------|----------|----------|-------------------------------------|----------|----------|----------|
|      | Male                | Female   | Male                                | Female   | Male     | Female   | Male                                | Female   | Male     | Female   |
| 81   | \$353.38            | \$304.71 | \$168.88                            | \$145.61 | \$279.17 | \$240.72 | \$117.25                            | \$101.10 | \$264.26 | \$227.86 |
| 82   | \$362.07            | \$310.79 | \$173.03                            | \$148.52 | \$286.04 | \$245.53 | \$120.13                            | \$103.12 | \$270.76 | \$232.41 |
| 83   | \$369.69            | \$315.98 | \$176.68                            | \$151.00 | \$292.06 | \$249.63 | \$122.66                            | \$104.84 | \$276.46 | \$236.30 |
| 84   | \$377.51            | \$321.35 | \$180.41                            | \$153.57 | \$298.23 | \$253.87 | \$125.26                            | \$106.62 | \$282.30 | \$240.31 |
| 85   | \$385.17            | \$326.56 | \$184.07                            | \$156.06 | \$304.28 | \$257.98 | \$127.80                            | \$108.35 | \$288.03 | \$244.21 |
| 86   | \$392.11            | \$331.15 | \$187.39                            | \$158.25 | \$309.77 | \$261.61 | \$130.10                            | \$109.88 | \$293.23 | \$247.64 |
| 87   | \$399.04            | \$335.75 | \$190.70                            | \$160.45 | \$315.24 | \$265.24 | \$132.40                            | \$111.40 | \$298.40 | \$251.08 |
| 88   | \$402.87            | \$339.61 | \$192.53                            | \$162.29 | \$318.27 | \$268.29 | \$133.67                            | \$112.68 | \$301.27 | \$253.96 |
| 89   | \$406.51            | \$343.28 | \$194.27                            | \$164.04 | \$321.14 | \$271.19 | \$134.88                            | \$113.90 | \$303.99 | \$256.71 |
| 90   | \$410.34            | \$346.95 | \$196.10                            | \$165.80 | \$324.17 | \$274.09 | \$136.15                            | \$115.12 | \$306.86 | \$259.45 |
| 91   | \$414.16            | \$350.61 | \$197.92                            | \$167.55 | \$327.18 | \$276.98 | \$137.42                            | \$116.33 | \$309.71 | \$262.19 |
| 92   | \$417.97            | \$354.47 | \$199.75                            | \$169.39 | \$330.20 | \$280.03 | \$138.68                            | \$117.61 | \$312.56 | \$265.08 |
| 93   | \$421.43            | \$357.93 | \$201.40                            | \$171.05 | \$332.93 | \$282.76 | \$139.83                            | \$118.76 | \$315.15 | \$267.66 |
| 94   | \$425.06            | \$361.42 | \$203.14                            | \$172.71 | \$335.80 | \$285.52 | \$141.04                            | \$119.92 | \$317.87 | \$270.27 |
| 95   | \$428.52            | \$364.90 | \$204.79                            | \$174.38 | \$338.53 | \$288.27 | \$142.18                            | \$121.07 | \$320.45 | \$272.88 |
| 96   | \$432.15            | \$368.37 | \$206.52                            | \$176.03 | \$341.40 | \$291.01 | \$143.39                            | \$122.23 | \$323.16 | \$275.47 |
| 97   | \$435.59            | \$371.84 | \$208.17                            | \$177.69 | \$344.12 | \$293.75 | \$144.53                            | \$123.38 | \$325.74 | \$278.06 |
| 98   | \$439.23            | \$375.30 | \$209.91                            | \$179.35 | \$346.99 | \$296.49 | \$145.74                            | \$124.53 | \$328.46 | \$280.66 |
| 99   | \$442.85            | \$378.78 | \$211.64                            | \$181.01 | \$349.85 | \$299.24 | \$146.94                            | \$125.68 | \$331.17 | \$283.26 |
| 100+ | \$442.85            | \$378.78 | \$211.64                            | \$181.01 | \$349.85 | \$299.24 | \$146.94                            | \$125.68 | \$331.17 | \$283.26 |

<sup>1</sup>Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

<sup>2</sup>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 57103, (877) 305-5463, TTY Number: (877) 652-1844, [shpcompliance@sanfordhealth.org](mailto: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







**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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