

Medicare SUPPLEMENT



OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

The Commissioner of Commerce of the state of Minnesota has established two categories of Medicare Supplements and minimum standards for each. Sanford Health Plan offers the Basic Plan, which has the least comprehensive coverage, and the Extended Basic Plan with the most comprehensive coverage.

The <i>Basic</i> Plan covers	
Hospitalization:	Part A coinsurance plus coverage for 100% of all Part A eligible expenses not covered by Medicare for the calendar year, after the deductible.
Skilled Nursing:	Daily copayment amount of Part A eligible expenses for days 21 through 100.
Blood (Part A & B):	First 3 pints of blood each year.
Medical Expenses:	Part B coinsurance or copay amount (20% of Medicare approved expenses) after the deductible.
Foreign Travel Emergency:	80% Foreign Travel Emergency Care
Optional Benefit Riders:	Rider 1 Part A Medicare Deductible Rider 2 Part B Medicare Deductible Rider 3 100% Part B Excess Expenses

The <i>Extended Basic</i> Plan includes all services listed above (including the Optional Benefit Riders 1, 2, and 3) and the following additional benefits:	
Additional Benefits:	80% Foreign Travel Care Skilled Nursing Care, 80% coverage for 20 additional days per calendar year. Preventive Care Benefit At-home Recovery Benefit Out-of-Pocket Maximum of \$1,000 per calendar year.

OUTLINE OF MEDICARE SUPPLEMENT PLAN COVERAGE
BASIC MEDICARE SUPPLEMENT
EXTENDED BASIC MEDICARE SUPPLEMENT

IMPORTANT INFORMATION READ YOUR MEMBERSHIP CONTRACT CAREFULLY

This is an outline describing your contract's most important features. It does not give all the details of Medicare coverage. Contact your local Social Security office or consult *Medicare & You* (sent by Medicare) for more details of Medicare coverage. The membership contract is your insurance contract. You must read the contract itself to understand all of the rights and duties of both you and your insurance company. Sanford Health Plan is not connected with Medicare. This contract may not cover all your medical costs.

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

This contract provides an anticipated loss ratio of 87%. This means that, on the average, policyholders may expect that \$87.00 of every \$100.00 in premium will be returned in the form of benefits to the policyholder over the life of the contract.

PREMIUMS AND RENEWABILITY

Sanford Health Plan guarantees to renew this contract as long as the premium is paid on or before the due date or within the grace period and you continue to live within the plans' service area. This contract will not be cancelled or non-renewed on the grounds of the deterioration of your health.

PREMIUMS

We may change the premium rates if we change all contracts with the same form numbers in the state in which you live. We will provide you written notice 30 days in advance of any changes in premium due to a change in benefits or a new table of rates. Benefits under this contract that are designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible and coinsurance percentage factors.

OTHER IMPORTANT INFORMATION

For most Services, if Medicare denies a charge, the Health Plan must deny it too. There are exceptions for some benefits that are required by Minnesota state law.

The State of Minnesota provides counseling services through Senior LinkAge. You can contact Senior LinkAge at 1-800-333-2433 to receive advice concerning the purchase of Medicare Supplement policies and enrollment under Medicaid. Contact the Minnesota Department of Commerce at 1-800-657-3602 for information about other Medicare Supplement products available in Minnesota.

NOTICE TO BUYER: This contract does not cover prescription drugs. Prescription drugs can be a very high percentage of your medical expenses. Coverage for prescription drugs may be available to use by retaining existing coverage you may have or by enrolling in Medicare Part D. Please ask your agent for further details.

MEMBER PREMIUM RATE

Type	Plan	Monthly Rate	Annual Rate
Non-Tobacco User	Basic Plan	\$104.12	\$1,249.44
	Part A Deductible Rider	\$27.38	\$328.56
	Part B Deductible Rider	\$9.13	\$109.56
	100% Part B Excess Rider	\$4.12	\$49.44
	Extended Basic Plan	\$312.36	\$3,748.32
Tobacco User	Basic Plan	\$115.71	\$1,388.52
	Part A Deductible Rider	\$30.39	\$364.68
	Part B Deductible Rider	\$9.13	\$109.56
	100% Part B Excess Rider	\$5.52	\$66.24
	Extended Basic Plan	\$347.13	\$4,165.56

NOTE: The Extended Basic Plan includes foreign travel medical services at 80% coverage, at-home recovery services and preventive care benefits.

RIGHT TO RETURN MEMBERSHIP CONTRACT

If you are not satisfied with your contract for any reason, you may return it to along with written notice of cancellation to your agent or Sanford Health Plan at P.O. Box 91110, Sioux Falls, SD 57109-1110

You may cancel your contract any time before midnight of the 10th day following the date of purchase. If the contract is a replacement policy, you may return the contract to us within 30 days after you receive it. Cancellation of your contract will make the policy void from its inception and we will treat the contract as if it had never been issued and will return your premium payments, including any applicable fees or charges, within 10 days after receiving notice of cancellation.

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

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

This contract does not cover all 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 contract.

NOTICE:

Items in brackets “[]” follow current Medicare amounts.

This Policy may not fully cover all of your medical costs nor does it give all the details of Medicare coverage. Contact your Social Security Office or consult the “Medicare and You Handbook” for more details.

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

THE PLAN'S SERVICE AREA

To be eligible to join Sanford Health Plan, you must live in one of these Minnesota counties: Cottonwood, Jackson, Lac Qui Parle, Lincoln, Lyon, Martin, Nobles , Murray, Pipestone, Redwood, Rock, Watonwan, or Yellow Medicine.

COMPLETING THE APPLICATION

Complete answers are very important: When completing the application for coverage, your signature verifies that you understand and agree that we will act reliance upon the information you have provided herein. When you fill out the application, be sure to answer truthfully and completely all questions about your medical health history. Sanford Health Plan may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. **NOTE:** If your policy is guranteed issue, this statment does not apply.

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

BENEFIT SUMMARY

Sanford Health Plan offers you two coverage options: the Basic Plan and the Extended Basic plan. The following summarizes your coverage, and how they compare to your benefits under standard Medicare. For detailed coverage terms and conditions, consult your Policy, or call Member Services at (605) 328-6800 or 1-800-752-5863.

BASIC PLAN MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD			
Services	Medicare Pays	Sanford Basic Plan Pays	You Pay
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but \$[1,068] deductible	Without Part A Rider: \$0 With Part A Rider: \$[1,068]	\$[1,068] \$0
61 st through 90 th day	All but \$[267] a day	\$[267] a day	\$0
91 st day and after	All but \$[534] a day	\$[534] a day 100% of Medicare Eligible Expenses	\$0
▪ While using 60 lifetime reserve days			
▪ Beyond the additional 150 days	\$0		\$0
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$[133.50] a day	Up to \$[133.50] a day	\$0
101 st day and after	\$0	\$0	All costs

*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.

**Once you have been billed \$135 of Medicare Approved Amounts for covered services, you Part B Deductible will have been met for the calendar year.

***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.

Services	Medicare Pays	Sanford Basic Plan Pays	You Pay
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for inpatient respite care.	\$0	Balance
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR			
MEDICAL EXPENSES Inpatient and outpatient hospital treatments such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostics tests, durable medical equipment First \$[135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts Part B Excess Charge (above Medicare Approved Amounts)	\$0 80% \$0	Without Part B Rider: \$0 With Part B Rider: \$[135] 20%*** Without Part B Excess Rider: \$0 With Part B Excess Rider: 100%	\$[135] \$0 \$0 All costs \$0
BLOOD First 3 pints Next \$[135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs Without Part B Rider: \$0 With Part B Rider: \$[135] 20%	\$0 \$[135] \$0 \$0

*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.

**Once you have been billed \$135 of Medicare Approved Amounts for covered services, you Part B Deductible will have been met for the calendar year.

***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.

Services	Medicare Pays	Sanford Basic Plan Pays	You Pay
CLINICAL LABORATORY SERVICES Tests for Diagnostic Services	100%	\$0	\$0
MEDICARE PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable Medical Equipment	100%	\$0	\$0
First \$[135] of Medicare Approved amounts**	\$0	Without Part B Rider: \$0 With Part B Rider: \$[135]	[\$135] \$0
Remainder of Medicare Approved amounts	80%	20%	\$0
FOREIGN TRAVEL NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during travel outside the United States (hospital, medical expense and supplies)	\$0	80% of covered expenses	Expenses not paid by Medicare or this policy
PREVENTIVE MEDICAL CARE BENEFIT FOR SERVICES NOT COVERED BY MEDICARE			
First \$120 each calendar year	\$0	\$0	\$120
Additional Charges	\$0	\$0	All costs

*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.

**Once you have been billed \$135 of Medicare Approved Amounts for covered services, you Part B Deductible will have been met for the calendar year.

***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.

**EXTENDED BASIC PLAN
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

Services	Medicare Pays	Sanford Extended Basic Plan Pays	You Pay
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but \$[1,068] deductible	\$[1,068] Part A deductible	\$0 \$0
61 st through 90 th day	All but \$[267] a day	\$[267] a day	\$0
91 st day and after	All but \$[534] a day	\$[534] a day	\$0
<ul style="list-style-type: none"> ▪ While using 60 lifetime reserve days ▪ Beyond the additional 150 days 	\$0	100% of Medicare Eligible Expenses	\$0 \$0
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$[133.50] a day	Up to \$[133.50] a day	\$0
101 st day and after	\$0	80% of covered expenses up to 120 days per calendar year	All costs

*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.

**Once you have been billed \$135 of Medicare Approved Amounts for covered services, you Part B Deductible will have been met for the calendar year.

***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.

Services	Medicare Pays	Sanford Extended Basic Plan Pays	You Pay
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for inpatient respite care	\$0	Balance
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR			
MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatments such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostics tests, durable medical equipment			
First \$[135] of Medicare Approved Amounts**	\$0	Without Part B Rider: \$0 With Part B Rider: \$[135]	\$[135] \$0
Remainder of Medicare Approved Amounts	80%	20%***	\$0
Part B Excess Charge (above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$[135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$[135] Part B Deductible 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES Tests for Diagnostic Services	100%	\$0	\$0

*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.

**Once you have been billed \$135 of Medicare Approved Amounts for covered services, you Part B Deductible will have been met for the calendar year.

***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.

MEDICARE PARTS A & B			
Services	Medicare Pays	Sanford Extended Basic Plan Pays	You Pay
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable Medical Equipment	100%	\$0	\$0
First \$[135] of Medicare Approved amounts**	\$0	[\$135] Part B Deductible	\$0
Remainder of Medicare Approved amounts	80%	20%	\$0
HOME HEALTH CARE AT HOME RECOVERY SERVICES NOT COVERED BY MEDICARE Home care certified by your doctor for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
Benefit for each visit	\$0	Actual charges to \$100.00 per visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare Approved visits (limited to 7 each week)	Balance
Calendar Year Maximum	\$0	[\$4,000]	Balance

*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.

**Once you have been billed \$135 of Medicare Approved Amounts for covered services, you Part B Deductible will have been met for the calendar year.

***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.

Services	Medicare Pays	Sanford Extended Basic Plan Pays	You Pay
FOREIGN TRAVEL NOT COVERED BY MEDICARE Medically necessary services during travel outside the United States	\$0	80% of covered expenses	Expenses not paid by Medicare or this policy
PREVENTIVE MEDICAL CARE BENEFIT FOR SERVICES NOT COVERED BY MEDICARE First \$120 each calendar year	\$0	\$120	\$0
Additional Charges	\$0	\$0	All costs

*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.

**Once you have been billed \$135 of Medicare Approved Amounts for covered services, you Part B Deductible will have been met for the calendar year.

***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.

ADDITIONAL BENEFITS UNDER THE BASIC AND EXTENDED PLANS

1. **Alcoholism. Chemical Dependency. Drug Addiction.** When you receive treatment in a licensed hospital, residential treatment program or nonresidential treatment program for alcoholism, chemical dependency or drug addiction, we will pay benefits on the same basis as coverage for any other condition. Benefits are not payable for that portion of expense that is paid by Medicare or paid under any other part of your policy.
2. **Scalp Hair Prosthesis.** We will pay the expense incurred on the same basis as any other sickness or injury and as if Medicare paid benefits for a scalp hair prosthesis needed because of hair loss suffered as a result of alopecia areata. Only the first \$350.00 of expense incurred in a calendar year will be considered as expense under this part of your policy. Amounts in excess of the reasonable charge are not considered expense. Benefits are not payable for that portion of expense that is paid by Medicare or paid under any other part of this policy.
3. **Routine Screening Procedures for Cancer.** We will pay the expense incurred that is not paid by Medicare or paid *under* any other part of your policy for routine screening procedures for cancer and the office or facility visit charge. Procedures include screening mammograms, Pap smears, colorectal screening tests and ovarian cancer surveillance tests.
4. **Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder.** Benefits are payable for the surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder on the same basis as that for treatment to any other joint in the body. Such treatment must be administered or prescribed by a physician or dentist. Benefits are not payable under this part of your policy for any expense payable under another part of the policy.
5. **Reconstructive Surgery.** Benefits are payable for reconstructive surgery on the same basis as that for any other surgery if the reconstructive surgery is incidental to or follows surgery resulting from injury, sickness or other disease of the involved part. Benefits are not payable under this policy for an expense payable under another part of the policy.
6. **Surgical Center Services.** Benefits are payable for surgical center services for health care treatment or service rendered by a freestanding ambulatory surgical center or facilities offering ambulatory medical service 24 hours a day, 7 days a week, which are not part of a hospital, but have been reviewed and approved by the state Commissioner of Commerce to provide the treatment or service on the same basis as coverage provided for the same health care treatment or service rendered by a hospital. Benefits are not payable under this part of your policy for an expense payable under another part of the policy.
7. **Immunization Benefits.** We will pay the expense incurred for an immunization received by you. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other portion of the policy.
8. **Phenylketonuria (PKU) Treatment.** Benefits are payable for special dietary treatment for phenylketonuria when recommended by a physician.
9. **Diabetes Equipment and Supplies.** We will pay the reasonable charge for expense incurred for all Physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes, not otherwise

covered under Medicare or Part D of the Medicare Program. Coverage must include persons with gestational, type I, or type II diabetes. Benefits will be limited to 80% of the reasonable charge not covered by Medicare or Part D of the Medicare Program.

10. **Routine Prostate Cancer Screening.** We will pay the expense incurred for prostate cancer screening. Benefits are limited to at least one screening per year for any insured male 50 years of age or older; and at least one screening per year for any insured male 40 years of age or older who is symptomatic.
11. **Mental Health Coverage.** For outpatient mental health care we will pay the allowable amount not paid by Medicare, less the Part B Deductible if applicable. Medicare limits apply. For inpatient mental health care we will pay benefits on the same basis as coverage for any other condition.
12. **Physical and Occupational Therapy Services.** We will pay the allowable amount not paid by Medicare, less the Part B Deductible if applicable.
13. **Treatment of Lyme Disease.** We will pay benefits for diagnosed Lyme disease as any other medical service. Benefits will not be payable for that portion of expense that is paid by Medicare or under any other part of your policy.

ADDITIONAL BENEFITS UNDER THE EXTENDED PLAN

Sanford Health Plan will pay 80% of the reasonable cost for the following services and supplies prescribed by a physician which are not paid by Medicare or payable under any other provision of your policy.

1. Hospital services.
2. Professional services of the diagnosis or treatment of injuries, sickness or conditions when such services are given by a physician or are under a physician's direction. Outpatient mental or dental services are not covered.
3. Services of a nursing home for not more than 120 days each year. Such services must qualify as reimbursable under Medicare.
4. Use of radium or other radioactive materials.
5. Oxygen.
6. Anesthetics.
7. Prosthetic device other than dental appliances.
8. Rental or purchase, as appropriate, of durable medical equipment other than eye glasses and hearing aids.
9. Diagnostic X-rays and laboratory tests.
10. Oral surgery for: a) partially or completely unerupted impacted teeth, b) a tooth root without the extraction of the entire tooth or c) the gums or tissues of the mouth when not performed in connection with the extraction or repair of teeth.
11. Services of a physical therapist.
12. Professional ambulance for service to the nearest facility qualified to treat the condition, or a reasonable mileage rate for transportation to a kidney dialysis center for treatment.
13. Well-baby care.
14. Up to \$500.00 for a second surgical opinion, excluding charges for the repetition of diagnostic tests.

15. Services of an occupational therapist.

EXCLUSIONS AND LIMITATIONS

This is a summary of items that are excluded from coverage. In addition to any other benefit exclusions or limitations specified in your Policy, Sanford Health Plan will not cover charges incurred for any of the following services.

1. Outpatient prescription drugs, except as specifically described in your Policy and except for certain drugs as covered by Medicare.
2. Eyewear (except as described in your Medicare Handbook), hearing aids or dentures.
3. Personal comfort items during hospital stays, for example, internet service or movies.
4. Private Duty Nursing.
5. Custodial nursing home care or intermediate nursing home care.
6. Inpatient mental health care in a Medicare-certified psychiatric hospital beyond Medicare's 190 day lifetime limit.
7. Hospital stays for "rest cures" or convalescence in a nursing home.
8. Cosmetic or reconstructive surgery except when those services are incidental to or follow surgery of an injury or illness of the affected body part.
9. Examinations for insurance or employment screening.
10. Transportation, except as specifically described in your Policy, and lodging or living expenses incidental to travel.
11. Health services that do not meet Medicare criteria, except those specifically described as covered in your Policy.
12. Physician charges above Medicare's approved charges, except as described in the Extended Basic Policy.
13. Any charge for care for injury or disease either a) arising out of an injury in the course of employment and subject to a workers' compensation or similar law, b) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-insurance, or c) for which benefits are payable under another policy of accident and health insurance, Medicare or any other governmental program.
14. Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a physician, provided however, that if the institution does not have semiprivate rooms, its most common semiprivate room charges shall be considered to be 90% of its lowest private room charge.
15. Part of any charge for services or supplies provided by or prescribed by a physician, dentist, or other health care professional which exceed the prevailing charge in the locality where the service is provided.
16. Any charge for services or supplies which are not within the scope of authorized practice of the institution or individual providing the services.



Sanford
Health Plan of Minnesota

Member Services (605) 328-6800

Toll-free: 1-800-752-5863

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