



MEDICARE SUPPLEMENT INSURANCE

Outline of Coverage | Iowa 2026

Index

To view the OOC for Iowa with plan effective dates through July 31, 2026, [CLICK HERE](#) (PG. 3)

To view the OOC for Iowa with plan effective dates as of August 1, 2026, [CLICK HERE](#) (PG. 17)



OOC THROUGH JULY 31, 2026

IOWA – AgilityPlus

Benefit Chart of Medicare Supplement Insurance Plans with effective dates on or after [January 1, 2026] Standard Medicare Supplement Plans A, G, and High Deductible G

These charts show the benefits included in each of the standard Medicare supplement plans. These amounts are based upon the most current Medicare deductible and cost sharing amounts and are subject to change. Every company must make Plan “A” available. Some plans may not be available in your state. See Outline of Coverage sections for details about available plans.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants									Medicare first eligible before 2020 only	
	A	B	D	G	HD Plan G	K	L	M	N	C	F
	Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	✓	50%	75%	✓	✓ copays apply ³	✓	✓
Blood (first three pints)	✓	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible										✓	✓
Medicare Part B excess charges				✓	✓						✓
Foreign travel emergency (up to plan limits)			80%	80%	80%			80%	80%	80%	80%
Out-of-pocket limit in [2026] ²						[\$8,000]	[\$4,000]				

1 Plan and G also has a high deductible option which require first paying a plan deductible of [\$2,950] 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 plan G counts your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

Service Area

Standard Plan Service Area: Buena Vista, Cherokee, Clay, Dickinson, Emmet, Ida, Lyon, O'Brien, Osceola, Palo Alto, Plymouth, Sioux, and Woodbury Counties. (Updated 4/1/2025)

Premium Information

Avera Health Plans can only raise your premium if we raise the premium for all policies like yours in this state. Your premiums are based on your attained age on the annual renewal date of your policy. The premiums shown in this booklet are for plan sold for effective dates on or after [April 1, 2025].

Household Premium Discount

You may be eligible for an AgilityPlus Standard Plan G policy with a lower premium rate if you currently reside with an individual with whom you have continuously resided for the last 12 months and who is age 60 or older.

Monthly Premium

ATTAINED AGE	AgilityPlus Standard Plan A		AgilityPlus Standard Plan G		AgilityPlus Household Discount Standard Plan G		AgilityPlus Standard Plan G High Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female
Under 65	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	\$118.22	\$103.70	\$157.85	\$138.39	\$138.91	\$121.78	\$69.12	\$60.63
66	\$118.22	\$103.70	\$157.85	\$138.39	\$138.91	\$121.78	\$69.12	\$60.63
67	\$118.22	\$103.70	\$157.85	\$138.39	\$138.91	\$121.78	\$69.12	\$60.63
68	\$124.20	\$108.95	\$164.99	\$144.65	\$145.19	\$127.29	\$72.24	\$63.37
69	\$127.68	\$112.00	\$169.18	\$148.34	\$148.88	\$130.54	\$74.09	\$64.99
70	\$133.49	\$117.10	\$176.48	\$154.75	\$155.30	\$136.18	\$77.29	\$67.80
71	\$139.08	\$122.00	\$183.53	\$160.91	\$161.51	\$141.60	\$80.36	\$70.49
72	\$146.17	\$128.22	\$192.49	\$168.74	\$169.39	\$148.49	\$84.27	\$73.92
73	\$159.18	\$139.63	\$209.18	\$183.38	\$184.08	\$161.37	\$91.59	\$80.34
74	\$166.46	\$146.02	\$218.26	\$191.42	\$192.07	\$168.45	\$95.60	\$83.86
75	\$175.99	\$154.38	\$230.36	\$201.93	\$202.72	\$177.70	\$100.86	\$88.47
76	\$183.26	\$160.75	\$239.34	\$209.95	\$210.62	\$184.76	\$104.86	\$91.98
77	\$189.60	\$166.32	\$247.32	\$216.95	\$217.64	\$190.92	\$108.36	\$95.05
78	\$194.89	\$170.96	\$253.98	\$222.79	\$223.50	\$196.06	\$111.26	\$97.60
79	\$199.02	\$174.58	\$259.17	\$227.34	\$228.07	\$200.06	\$113.54	\$99.60
80	\$203.24	\$178.28	\$264.47	\$231.99	\$232.73	\$204.15	\$115.87	\$101.64
81	\$207.55	\$182.06	\$269.90	\$236.75	\$237.51	\$208.34	\$118.24	\$103.72

ATTAINED AGE	AgilityPlus Standard Plan A		AgilityPlus Standard Plan G		AgilityPlus Household Discount Standard Plan G		AgilityPlus Standard Plan G High Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female
82	\$211.95	\$185.92	\$275.42	\$241.60	\$242.37	\$212.61	\$120.67	\$105.85
83	\$216.43	\$189.85	\$281.07	\$246.55	\$247.34	\$216.96	\$123.13	\$108.01
84	\$221.01	\$193.87	\$286.84	\$251.61	\$252.42	\$221.42	\$125.66	\$110.23
85	\$225.70	\$197.98	\$292.73	\$256.78	\$257.60	\$225.97	\$128.25	\$112.50
86	\$230.63	\$202.31	\$298.93	\$262.22	\$263.06	\$230.75	\$130.96	\$114.88
87	\$235.67	\$206.73	\$305.27	\$267.78	\$268.64	\$235.65	\$133.73	\$117.31
88	\$240.81	\$211.24	\$311.73	\$273.45	\$274.32	\$240.64	\$136.57	\$119.80
89	\$246.06	\$215.84	\$318.33	\$279.24	\$280.13	\$245.73	\$139.46	\$122.33
90	\$251.43	\$220.55	\$325.08	\$285.16	\$286.07	\$250.94	\$142.42	\$124.93
91	\$256.90	\$225.35	\$331.97	\$291.20	\$292.13	\$256.26	\$145.43	\$127.57
92	\$262.49	\$230.25	\$339.00	\$297.37	\$298.32	\$261.69	\$148.52	\$130.28
93	\$268.20	\$235.26	\$346.18	\$303.67	\$304.64	\$267.23	\$151.67	\$133.04
94	\$274.03	\$240.38	\$353.53	\$310.11	\$311.11	\$272.90	\$154.88	\$135.86
95	\$279.98	\$245.60	\$361.02	\$316.68	\$317.70	\$278.68	\$158.16	\$138.74
96	\$286.07	\$250.94	\$368.66	\$323.39	\$324.42	\$284.58	\$161.52	\$141.68
97	\$292.27	\$256.38	\$376.47	\$330.24	\$331.29	\$290.61	\$164.94	\$144.68
98	\$298.62	\$261.95	\$384.45	\$337.24	\$338.32	\$296.77	\$168.42	\$147.74
99	\$305.10	\$267.63	\$392.59	\$344.38	\$345.48	\$303.05	\$171.99	\$150.87
100+	\$311.71	\$273.43	\$400.92	\$351.68	\$352.81	\$309.48	\$175.64	\$154.07

DISCLOSURES

Use this Outline of Coverage to compare benefits and premiums among policies. This outline shows benefits of AgilityPlus policies sold for effective dates on or after [January 1, 2026]. Policies sold for effective dates prior to [January 1, 2026] may have different premiums. You do not need more than one Medicare Supplement Insurance Policy. You must be enrolled in Part A and Part B Medicare coverage and use a Medicare-approved hospital.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and complete all questions about your medical and health history. We 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.

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 the rights and duties of both you and Avera Health Plans.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Service Center at Avera Health Plans, 5300 S. Broadband Ln., Sioux Falls, SD 57108-2221 or your agent. If you send your policy back to us within 30 days after you receive it, we will treat your policy as if it had never been issued and return all your payments.

REFUND OF PREMIUM

If termination is due to you ceasing to be eligible for this plan or we receive written notice that you wish to terminate your coverage, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded.

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 “[]” follow current Medicare amounts and dates.

This policy may not fully cover all of your medical costs. Neither Avera Health Plans nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult “Medicare & You” for more details.

LIMITATIONS AND EXCLUSIONS

Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid. We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions. There are no exceptions or limitations under the Enhanced Benefits - only what is covered.

No benefits will be paid under Medicare Part A which duplicate payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicate payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
HOSPITALIZATION ² Semi-private room and board, general nursing and miscellaneous services and supplies <div style="text-align: right; margin-right: 50px;"> First 60 days 61st day through 90th day 91st day and after (While using 60 lifetime reserve days) </div> <div style="text-align: right; margin-right: 50px;"> Once lifetime reserve days are used -Additional 365 days -Beyond the Additional 365days </div>	<div style="text-align: right; margin-right: 50px;"> All but \$[1,736] All but \$[434] per day All but \$[868] per day </div> <div style="text-align: right; margin-right: 50px;"> \$0 \$[434] per day \$[868] per day </div> <div style="text-align: right; margin-right: 50px;"> \$0 \$0 </div>	<div style="text-align: right; margin-right: 50px;"> \$0 \$[434] per day \$[868] per day </div> <div style="text-align: right; margin-right: 50px;"> 100% Medicare Eligible Expense \$0 </div>	<div style="text-align: right; margin-right: 50px;"> \$[1,736] (Part A Deductible) \$0 \$0 </div> <div style="text-align: right; margin-right: 50px;"> \$0³ All Costs </div>
SKILLED NURSING FACILITYCARE ² 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.	<div style="text-align: right; margin-right: 50px;"> All approved amounts All but \$[217] per day \$0 </div>	<div style="text-align: right; margin-right: 50px;"> \$0 \$0 \$0 </div>	<div style="text-align: right; margin-right: 50px;"> \$0 Up to \$[217] per day All Costs </div>
BLOOD	<div style="text-align: right; margin-right: 50px;"> \$0 100% </div>	<div style="text-align: right; margin-right: 50px;"> 3 pints \$0 </div>	<div style="text-align: right; margin-right: 50px;"> \$0 \$0 </div>
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	<div style="text-align: right; margin-right: 50px;"> All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care </div>	<div style="text-align: right; margin-right: 50px;"> Medicare copayment/coinsurance </div>	<div style="text-align: right; margin-right: 50px;"> \$0 </div>

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² A benefit period begins on the first day you receive service 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.

³ 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.

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[283] of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[283] (Part B Deductible) \$0
PART B EXCESS CHARGES Above Medicare-Approved Amounts	\$0	\$0	All Costs
BLOOD First 3 pints Next \$[283] of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[283] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICE Tests For Diagnostic Services	100%	\$0	\$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

HOME HEALTH CARE MEDICARE-APPROVED SERVICES -Medically necessary skilled care services and medical supplies Durable medical equipment First \$[283] of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[283] (Part B Deductible) \$0
--	------------------------	-----------------------	---

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² After you have been billed \$[283] of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
HOSPITALIZATION² Semi-private room and board, general nursing and miscellaneous services and supplies <div style="text-align: right;"> First 60 days 61st day through 90th day 91st day and after (While using 60 lifetime reserve days) </div> <div style="text-align: right;"> Once lifetime reserve days are used -Additional 365 days -Beyond the Additional 365 days </div>	<div style="text-align: right;"> All but \$[1,736] All but \$[434] per day All but \$[868] per day </div> <div style="text-align: right;"> \$0 \$0 </div>	<div style="text-align: right;"> \$[1,736] (Part A Deductible) \$[434] per day \$[868] per day </div> <div style="text-align: right;"> 100% Medicare Eligible Expense \$0 </div>	<div style="text-align: right;"> \$0 \$0 \$0 </div> <div style="text-align: right;"> \$0³ All Costs </div>
SKILLED NURSING FACILITYCARE² 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.	<div style="text-align: right;"> All approved amounts All but \$[217] per day \$0 </div>	<div style="text-align: right;"> \$0 Up to \$[217] per day \$0 </div>	<div style="text-align: right;"> \$0 \$0 All Costs </div>
BLOOD <div style="text-align: right;"> First 3 pints Additional amounts </div>	<div style="text-align: right;"> \$0 100% </div>	<div style="text-align: right;"> 3 pints \$0 </div>	<div style="text-align: right;"> \$0 \$0 </div>
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	<div style="text-align: right;"> All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care. </div>	<div style="text-align: right;"> Medicare copayment/coinsurance </div>	<div style="text-align: right;"> \$0 </div>

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² A benefit period begins on the first day you receive service 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.

³ When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

SERVICES	MEDICARE PAYS	PLAN PAYS	DEDUCTIBLE YOU PAY ¹
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[283] of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[283] (Part B Deductible) \$0
PART B EXCESS CHARGES Above Medicare-Approved Amounts	\$0	100% Medicare Eligible Costs	\$0
BLOOD First 3 pints Next \$[283] of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[283] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICE Tests For Diagnostic Services	100%	\$0	\$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

HOME HEALTH CARE MEDICARE-APPROVED SERVICES -Medically necessary skilled care services and medical supplies Durable medical equipment First \$[283] of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[283] (Part B Deductible) \$0
FOREIGN TRAVEL- NOT COVERED BY MEDICARE Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA. First \$250 each Calendar Year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² After you have been billed \$[283] of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2,950] DEDUCTIBLE ⁴ PLAN PAYS	IN ADDITION TO \$[2,950] DEDUCTIBLE ⁴ YOU PAY ¹
HOSPITALIZATION² Semiprivate room and board, general nursing and miscellaneous services and supplies <div style="text-align: right; margin-right: 100px;"> First 60 days 61st day through 90th day 91st day and after (While using 60 lifetime reserve days) </div> <div style="text-align: right; margin-right: 100px;"> Once lifetime reserve days are used -Additional 365 days -Beyond the Additional 365 days </div>	All but \$[1,736] All but \$[434] per day All but \$[868] per day \$0 \$0	\$[1,736] (Part A Deductible) \$[434] per day \$[868] per day 100% Medicare Eligible Expense \$0	\$0 \$0 \$0 \$0 ³ All Costs
SKILLED NURSING FACILITY CARE² 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.	All approved amounts All but \$[217] per day \$0	\$0 Up to \$[217] per day \$0	\$0 \$0 All Costs
BLOOD <div style="text-align: right; margin-right: 100px;"> First 3 pints Additional amounts </div>	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	\$0

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² A benefit period begins on the first day you receive service 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.

³ 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.

⁴ This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$[2,950] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$[2,950]. 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.

High Deductible Plan G

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2,950] DEDUCTIBLE PLAN PAYS	IN ADDITION TO \$[2,950] DEDUCTIBLE YOU PAY ¹
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment <div style="display: flex; justify-content: space-between;"> First \$[283] of Medicare-Approved Amounts² \$0 \$0 \$[283] (Part B Deductible) </div> <div style="display: flex; justify-content: space-between;"> Remainder of Medicare-Approved Amounts Generally 80% Generally 20% \$0 </div>			
PART B EXCESS CHARGES <div style="display: flex; justify-content: space-between;"> Above Medicare-Approved Amounts \$0 100% Medicare Eligible Costs \$0 </div>			
BLOOD <div style="display: flex; justify-content: space-between;"> First 3 pints \$0 All costs \$0 </div> <div style="display: flex; justify-content: space-between;"> Next \$[283] of Medicare-Approved Amounts² \$0 \$0 \$[283] (Part B Deductible) </div> <div style="display: flex; justify-content: space-between;"> Remainder of Medicare-Approved Amounts 80% 20% \$0 </div>			
CLINICAL LABORATORY SERVICE <div style="display: flex; justify-content: space-between;"> Tests For Diagnostic Services 100% \$0 \$0 </div>			

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

HOME HEALTH CARE MEDICARE-APPROVED SERVICES -Medically necessary skilled care services and medical supplies <div style="display: flex; justify-content: space-between;"> Durable medical equipment \$0 \$0 \$[283] (Part B Deductible) </div> <div style="display: flex; justify-content: space-between;"> First \$[283] of Medicare-Approved Amounts² 80% 20% \$0 </div> <div style="display: flex; justify-content: space-between;"> Remainder of Medicare-Approved Amounts 80% 20% \$0 </div>			
FOREIGN TRAVEL- NOT COVERED BY MEDICARE Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA. <div style="display: flex; justify-content: space-between;"> First \$250 each Calendar Year \$0 \$0 \$250 </div> <div style="display: flex; justify-content: space-between;"> Remainder of Charges \$0 80% to a lifetime maximum benefit of \$50,000 20% and amounts over the \$50,000 lifetime maximum </div>			

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² After you have been billed \$[283] of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**AGILITYPLUS PLAN G ADDITIONAL BENEFITS
ENHANCED BENEFITS – PER CALENDAR YEAR**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
Benefit:¹			
Annual routine physical exam once every 12 months	\$0	100%	\$0
Initial Hearing Exam & Aid Fitting for new patients	\$0	100%	\$0
Heart and Vascular Screening: Coverage of screening through Planet Heart program with Avera at one of the locations offered throughout South Dakota & Iowa	\$0	100%	\$0

We will pay the expenses incurred by you for enhanced benefit services for routine annual physical, hearing exam/screening/fitting, and heart and vascular screening as defined below, if such expenses are determined to be medically appropriate by an attending physician and such expenses are not paid for by Medicare or any other provision of this policy. Details for the benefits and coverage provided in the policy.

Routine Annual Physical Exam: Expenses incurred by you for routine annual physical exams to prevent or detect illness at an early stage, prior to the development of any symptoms, and subject to the following exclusions:

1. Dental services defined by American Dental Association Current Dental Terminology (CDT) codes;
2. Chiropractic services, acupuncture, and acupressure services;
3. Weight loss treatment of any type;
4. Prescription drugs or over-the-counter drugs or supplements;
5. Experimental preventive services.

Hearing Exam/Screening/Fitting: Expenses incurred by you for Hearing exam/screening/fitting listed below are covered expenses:

1. Routine hearing examination/screening to determine hearing loss
2. Initial hearing aid fitting: no coverage for overall hearing aids, coverage is for the fitting service only

¹ We will pay the expenses incurred by You if such expenses are determined to be medically appropriate by an attending physician and such expenses are not paid for by Medicare or any other provision of this policy.

AGILITYPLUS PLAN G ADDITIONAL BENEFITS

Heart and Vascular Screening: Coverage offered through the Planet Heart program, the screening is a comprehensive assessment conducted by heart professionals that check the health of the heart and vascular systems. In addition to ultrasounds and a CT scan, you'll get a risk assessment for cardiovascular disease and education including a diet quality index, nutrition counseling and if needed, an introduction to tobacco cessation. After each screening, the results are read by a radiologist and get sent to the requested primary care provider. The following is included in the screening:

1. Carotid artery scan and ultrasound
2. Abdominal aortic aneurysm scan and ultrasound
3. Blood Pressures of both arms and legs Ankle Brachial Index/ABI
4. Calcium Score CAT SCAN / CT
5. Individual Health Assessment
6. Total Cholesterol Screen (4 hour-fasting)
7. Glucose (Blood Sugar) Screen (4 hour-fasting)
8. Body Mass Index screening/calculation
9. CT Scan reviewed by a radiologist and file sent to the patient's primary care provider
10. Consultation with Cardiovascular Specialty RN
11. Consultation with Dietitian optional telephone consult
12. Consultation with Smoking Cessation Specialist optional telephone consult



OOC AS OF AUGUST 1, 2026

IOWA – AgilityPlus

**Benefit Chart of Medicare Supplement Insurance Plans with effective dates on or after [August 1, 2026]
Standard Medicare Supplement Plans A, G, and High Deductible G**

These charts show the benefits included in each of the standard Medicare supplement plans. These amounts are based upon the most current Medicare deductible and cost sharing amounts and are subject to change. Every company must make Plan “A” available. Some plans may not be available in your state. See Outline of Coverage sections for details about available plans.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants									Medicare first eligible before 2020 only	
	A	B	D	G	HD Plan G	K	L	M	N	C	F
	Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	✓	50%	75%	✓	✓ copays apply ³	✓	✓
Blood (first three pints)	✓	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible										✓	✓
Medicare Part B excess charges				✓	✓						✓
Foreign travel emergency (up to plan limits)			80%	80%	80%			80%	80%	80%	80%
Out-of-pocket limit in [2026] ²						[\$8,000]	[\$4,000]				

1 Plan and G also has a high deductible option which require first paying a plan deductible of [\$2,950] 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 plan G counts your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

Service Area

Standard Plan Service Area: Buena Vista, Cherokee, Clay, Dickinson, Emmet, Ida, Lyon, O'Brien, Osceola, Palo Alto, Plymouth, Sioux, and Woodbury Counties. (Updated 4/1/2025)

Premium Information

Avera Health Plans can only raise your premium if we raise the premium for all policies like yours in this state. Your premiums are based on your attained age on the annual renewal date of your policy. The premiums shown in this booklet are for plan sold for effective dates on or after [August 1, 2026].

Household Premium Discount

You may be eligible for an AgilityPlus Standard Plan G policy with a lower premium rate if you currently reside with an individual with whom you have continuously resided for the last 12 months and who is age 60 or older.

Monthly Premium

ATTAINED AGE	AgilityPlus Standard Plan A		AgilityPlus Standard Plan G		AgilityPlus Household Discount Standard Plan G		AgilityPlus Standard Plan G High Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female
Under 65	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	\$126.50	\$110.96	\$168.90	\$148.08	\$148.63	\$130.30	\$73.96	\$64.87
66	\$126.50	\$110.96	\$168.90	\$148.08	\$148.63	\$130.30	\$73.96	\$64.87
67	\$126.50	\$110.96	\$168.90	\$148.08	\$148.63	\$130.30	\$73.96	\$64.87
68	\$132.89	\$116.58	\$176.54	\$154.78	\$155.35	\$136.20	\$77.30	\$67.81
69	\$136.62	\$119.84	\$181.02	\$158.72	\$159.30	\$139.68	\$79.28	\$69.54
70	\$142.83	\$125.30	\$188.83	\$165.58	\$166.17	\$145.71	\$82.70	\$72.55
71	\$148.82	\$130.54	\$196.38	\$172.17	\$172.82	\$151.51	\$85.99	\$75.42
72	\$156.40	\$137.20	\$205.96	\$180.55	\$181.25	\$158.88	\$90.17	\$79.09
73	\$170.32	\$149.40	\$223.82	\$196.22	\$196.97	\$172.67	\$98.00	\$85.96
74	\$178.11	\$156.24	\$233.54	\$204.82	\$205.51	\$180.24	\$102.29	\$89.73
75	\$188.31	\$165.19	\$246.49	\$216.07	\$216.91	\$190.14	\$107.92	\$94.66
76	\$196.09	\$172.00	\$256.09	\$224.65	\$225.36	\$197.69	\$112.20	\$98.42
77	\$202.87	\$177.96	\$264.63	\$232.14	\$232.87	\$204.28	\$115.95	\$101.70
78	\$208.53	\$182.93	\$271.76	\$238.39	\$239.15	\$209.78	\$119.05	\$104.43
79	\$212.95	\$186.80	\$277.31	\$243.25	\$244.03	\$214.06	\$121.49	\$106.57
80	\$217.47	\$190.76	\$282.98	\$248.23	\$249.02	\$218.44	\$123.98	\$108.75
81	\$222.08	\$194.80	\$288.79	\$253.32	\$254.14	\$222.92	\$126.52	\$110.98

ATTAINED AGE	AgilityPlus Standard Plan A		AgilityPlus Standard Plan G		AgilityPlus Household Discount Standard Plan G		AgilityPlus Standard Plan G High Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female
82	\$226.79	\$198.93	\$294.70	\$258.51	\$259.34	\$227.49	\$129.12	\$113.26
83	\$231.58	\$203.14	\$300.74	\$263.81	\$264.65	\$232.15	\$131.75	\$115.57
84	\$236.48	\$207.44	\$306.92	\$269.22	\$270.09	\$236.92	\$134.46	\$117.95
85	\$241.50	\$211.84	\$313.22	\$274.75	\$275.63	\$241.79	\$137.23	\$120.38
86	\$246.77	\$216.47	\$319.86	\$280.58	\$281.47	\$246.90	\$140.13	\$122.92
87	\$252.17	\$221.20	\$326.64	\$286.52	\$287.44	\$252.15	\$143.09	\$125.52
88	\$257.67	\$226.03	\$333.55	\$292.59	\$293.52	\$257.48	\$146.13	\$128.19
89	\$263.28	\$230.95	\$340.61	\$298.79	\$299.74	\$262.93	\$149.22	\$130.89
90	\$269.03	\$235.99	\$347.84	\$305.12	\$306.09	\$268.51	\$152.39	\$133.68
91	\$274.88	\$241.12	\$355.21	\$311.58	\$312.58	\$274.20	\$155.61	\$136.50
92	\$280.86	\$246.37	\$362.73	\$318.19	\$319.20	\$280.01	\$158.92	\$139.40
93	\$286.97	\$251.73	\$370.41	\$324.93	\$325.96	\$285.94	\$162.29	\$142.35
94	\$293.21	\$257.21	\$378.28	\$331.82	\$332.89	\$292.00	\$165.72	\$145.37
95	\$299.58	\$262.79	\$386.29	\$338.85	\$339.94	\$298.19	\$169.23	\$148.45
96	\$306.09	\$268.51	\$394.47	\$346.03	\$347.13	\$304.50	\$172.83	\$151.60
97	\$312.73	\$274.33	\$402.82	\$353.36	\$354.48	\$310.95	\$176.49	\$154.81
98	\$319.52	\$280.29	\$411.36	\$360.85	\$362.00	\$317.54	\$180.21	\$158.08
99	\$326.46	\$286.36	\$420.07	\$368.49	\$369.66	\$324.26	\$184.03	\$161.43
100+	\$333.53	\$292.57	\$428.98	\$376.30	\$377.51	\$331.14	\$187.93	\$164.85

DISCLOSURES

Use this Outline of Coverage to compare benefits and premiums among policies. This outline shows benefits of AgilityPlus policies sold for effective dates on or after [August 1, 2026]. Policies sold for effective dates prior to [August 1, 2026] may have different premiums. You do not need more than one Medicare Supplement Insurance Policy. You must be enrolled in Part A and Part B Medicare coverage and use a Medicare-approved hospital.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and complete all questions about your medical and health history. We 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.

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 the rights and duties of both you and Avera Health Plans.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Service Center at Avera Health Plans, 5300 S. Broadband Ln., Sioux Falls, SD 57108-2221 or your agent. If you send your policy back to us within 30 days after you receive it, we will treat your policy as if it had never been issued and return all your payments.

REFUND OF PREMIUM

If termination is due to you ceasing to be eligible for this plan or we receive written notice that you wish to terminate your coverage, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded.

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 “[]” follow current Medicare amounts and dates.

This policy may not fully cover all of your medical costs. Neither Avera Health Plans nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult “Medicare & You” for more details.

LIMITATIONS AND EXCLUSIONS

Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid. We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions. There are no exceptions or limitations under the Enhanced Benefits - only what is covered.

No benefits will be paid under Medicare Part A which duplicate payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicate payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
HOSPITALIZATION ² Semi-private room and board, general nursing and miscellaneous services and supplies <div style="text-align: right; margin-right: 100px;"> First 60 days 61st day through 90th day 91st day and after (While using 60 lifetime reserve days) </div> <div style="text-align: right; margin-right: 100px;"> Once lifetime reserve days are used -Additional 365days -Beyond the Additional 365days </div>	<div style="text-align: right; margin-right: 100px;"> All but \$[1,736] All but \$[434] per day All but \$[868] per day </div> <div style="text-align: right; margin-right: 100px;"> \$0 \$[434] per day \$[868] per day </div> <div style="text-align: right; margin-right: 100px;"> \$0 \$0 </div>	<div style="text-align: right; margin-right: 100px;"> \$0 \$[434] per day \$[868] per day </div> <div style="text-align: right; margin-right: 100px;"> 100% Medicare Eligible Expense \$0 </div>	<div style="text-align: right; margin-right: 100px;"> \$[1,736] (Part A Deductible) \$0 \$0 </div> <div style="text-align: right; margin-right: 100px;"> \$0³ All Costs </div>
SKILLED NURSING FACILITYCARE ² 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.	<div style="text-align: right; margin-right: 100px;"> First 20 days 21st thru 100th day 101st day and after </div> <div style="text-align: right; margin-right: 100px;"> All approved amounts All but \$[217] per day \$0 </div>	<div style="text-align: right; margin-right: 100px;"> \$0 \$0 \$0 </div>	<div style="text-align: right; margin-right: 100px;"> \$0 Up to \$[217] per day All Costs </div>
BLOOD	<div style="text-align: right; margin-right: 100px;"> First 3 pints Additional amounts </div> <div style="text-align: right; margin-right: 100px;"> \$0 100% </div>	<div style="text-align: right; margin-right: 100px;"> 3 pints \$0 </div>	<div style="text-align: right; margin-right: 100px;"> \$0 \$0 </div>
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	<div style="text-align: right; margin-right: 100px;"> All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care </div>	<div style="text-align: right; margin-right: 100px;"> Medicare copayment/coinsurance </div>	<div style="text-align: right; margin-right: 100px;"> \$0 </div>

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² A benefit period begins on the first day you receive service 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.

³ 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.

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[283] of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$[283] (Part B Deductible) \$0
PART B EXCESS CHARGES Above Medicare-Approved Amounts	 \$0	 \$0	 All Costs
BLOOD First 3 pints Next \$[283] of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$[283] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICE Tests For Diagnostic Services	 100%	 \$0	 \$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

HOME HEALTH CARE MEDICARE-APPROVED SERVICES -Medically necessary skilled care services and medical supplies Durable medical equipment First \$[283] of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	 100% \$0 80%	 \$0 \$0 20%	 \$0 \$[283] (Part B Deductible) \$0
--	----------------------------	-----------------------	---

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² After you have been billed \$[283] of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
HOSPITALIZATION² Semi-private room and board, general nursing and miscellaneous services and supplies <div style="text-align: right;"> First 60 days 61st day through 90th day 91st day and after (While using 60 lifetime reserve days) </div> <div style="text-align: right;"> Once lifetime reserve days are used -Additional 365 days -Beyond the Additional 365 days </div>	<div style="text-align: right;"> All but \$[1,736] All but \$[434] per day All but \$[868] per day </div> <div style="text-align: right;"> \$0 \$0 </div>	<div style="text-align: right;"> \$[1,736] (Part A Deductible) \$[434] per day \$[868] per day </div> <div style="text-align: right;"> 100% Medicare Eligible Expense \$0 </div>	<div style="text-align: right;"> \$0 \$0 \$0 </div> <div style="text-align: right;"> \$0³ All Costs </div>
SKILLED NURSING FACILITYCARE² 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. <div style="text-align: right;"> First 20 days 21st thru 100th day 101st day and after </div>	<div style="text-align: right;"> All approved amounts All but \$[217] per day \$0 </div>	<div style="text-align: right;"> \$0 Up to \$[217] per day \$0 </div>	<div style="text-align: right;"> \$0 \$0 All Costs </div>
BLOOD <div style="text-align: right;"> First 3 pints Additional amounts </div>	<div style="text-align: right;"> \$0 100% </div>	<div style="text-align: right;"> 3 pints \$0 </div>	<div style="text-align: right;"> \$0 \$0 </div>
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	<div style="text-align: right;"> All but very limited copayment/coinsurancefor outpatient drugs and inpatient respite care. </div>	<div style="text-align: right;"> Medicare copayment/coinsurance </div>	<div style="text-align: right;"> \$0 </div>

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² A benefit period begins on the first day you receive service 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.

³ When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

SERVICES	MEDICARE PAYS	PLAN PAYS	DEDUCTIBLE YOU PAY ¹
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[283] of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[283] (Part B Deductible) \$0
PART B EXCESS CHARGES Above Medicare-Approved Amounts	\$0	100% Medicare Eligible Costs	\$0
BLOOD First 3 pints Next \$[283] of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[283] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICE Tests For Diagnostic Services	100%	\$0	\$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

HOME HEALTH CARE MEDICARE-APPROVED SERVICES -Medically necessary skilled care services and medical supplies Durable medical equipment First \$[283] of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[283] (Part B Deductible) \$0
FOREIGN TRAVEL- NOT COVERED BY MEDICARE Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA. First \$250 each Calendar Year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² After you have been billed \$[283] of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2,950] DEDUCTIBLE ⁴ PLAN PAYS	IN ADDITION TO \$[2,950] DEDUCTIBLE ⁴ YOU PAY ¹
HOSPITALIZATION² Semiprivate room and board, general nursing and miscellaneous services and supplies <div style="text-align: right;"> First 60 days 61st day through 90th day 91st day and after (While using 60 lifetime reserve days) </div> <div style="text-align: right;"> Once lifetime reserve days are used -Additional 365 days -Beyond the Additional 365 days </div>	<div style="text-align: right;"> All but \$[1,736] All but \$[434] per day All but \$[868] per day </div> <div style="text-align: right;"> \$0 \$0 </div>	<div style="text-align: right;"> \$[1,736] (Part A Deductible) \$[434] per day \$[868] per day </div> <div style="text-align: right;"> 100% Medicare Eligible Expense \$0 </div>	<div style="text-align: right;"> \$0 \$0 \$0 </div> <div style="text-align: right;"> \$0³ All Costs </div>
SKILLED NURSING FACILITY CARE² 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.	<div style="text-align: right;"> First 20 days 21st thru 100th day 101st day and after </div> <div style="text-align: right;"> All approved amounts All but \$[217] per day \$0 </div>	<div style="text-align: right;"> \$0 Up to \$[217] per day \$0 </div>	<div style="text-align: right;"> \$0 \$0 All Costs </div>
BLOOD	<div style="text-align: right;"> First 3 pints Additional amounts </div> <div style="text-align: right;"> \$0 100% </div>	<div style="text-align: right;"> 3 pints \$0 </div>	<div style="text-align: right;"> \$0 \$0 </div>
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	<div style="text-align: right;"> All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care. </div>	<div style="text-align: right;"> Medicare copayment/coinsurance </div>	<div style="text-align: right;"> \$0 </div>

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² A benefit period begins on the first day you receive service 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.

³ 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.

⁴ This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$[2,950] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$[2,950]. 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.

High Deductible Plan G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2,950] DEDUCTIBLE PLAN PAYS	IN ADDITION TO \$[2,950] DEDUCTIBLE YOU PAY ¹
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[283] of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[283] (Part B Deductible) \$0
PART B EXCESS CHARGES Above Medicare-Approved Amounts	\$0	100% Medicare Eligible Costs	\$0
BLOOD First 3 pints Next \$[283] of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[283] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICE Tests For Diagnostic Services	100%	\$0	\$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

HOME HEALTH CARE MEDICARE-APPROVED SERVICES -Medically necessary skilled care services and medical supplies Durable medical equipment First \$[283] of Medicare-Approved Amounts ² Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[283] (Part B Deductible) \$0
FOREIGN TRAVEL- NOT COVERED BY MEDICARE Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA. First \$250 each Calendar Year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

¹ Indicates your liability for covered charges. You are responsible for all other non-covered charges.

² After you have been billed \$[283] of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**AGILITYPLUS PLAN G ADDITIONAL BENEFITS
ENHANCED BENEFITS – PER CALENDAR YEAR**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY ¹
Benefit:¹			
Annual routine physical exam once every 12 months	\$0	100%	\$0
Initial Hearing Exam & Aid Fitting for new patients	\$0	100%	\$0
Heart and Vascular Screening: Coverage of screening through Planet Heart program with Avera at one of the locations offered throughout South Dakota & Iowa	\$0	100%	\$0

We will pay the expenses incurred by you for enhanced benefit services for routine annual physical, hearing exam/screening/fittings, and heart and vascular screening as defined below, if such expenses are determined to be medically appropriate by an attending physician and such expenses are not paid for by Medicare or any other provision of this policy. Details for the benefits and coverage provided in the policy.

Routine Annual Physical Exam: Expenses incurred by you for routine annual physical exams to prevent or detect illness at an early stage, prior to the development of any symptoms, and subject to the following exclusions:

1. Dental services defined by American Dental Association Current Dental Terminology (CDT) codes;
2. Chiropractic services, acupuncture, and acupressure services;
3. Weight loss treatment of any type;
4. Prescription drugs or over-the-counter drugs or supplements;
5. Experimental preventive services.

Hearing Exam/Screening/Fitting: Expenses incurred by you for Hearing exam/screening/fitting listed below are covered expenses:

1. Routine hearing examination/screening to determine hearing loss
2. Initial hearing aid fitting: no coverage for overall hearing aids, coverage is for the fitting service only

¹ We will pay the expenses incurred by You if such expenses are determined to be medically appropriate by an attending physician and such expenses are not paid for by Medicare or any other provision of this policy.

AGILITYPLUS PLAN G ADDITIONAL BENEFITS

Heart and Vascular Screening: Coverage offered through the Planet Heart program, the screening is a comprehensive assessment conducted by heart professionals that check the health of the heart and vascular systems. In addition to ultrasounds and a CT scan, you'll get a risk assessment for cardiovascular disease and education including a diet quality index, nutrition counseling and if needed, an introduction to tobacco cessation. After each screening, the results are read by a radiologist and get sent to the requested primary care provider. The following is included in the screening:

1. Carotid artery scan and ultrasound
2. Abdominal aortic aneurysm scan and ultrasound
3. Blood Pressures of both arms and legs Ankle Brachial Index/ABI
4. Calcium Score CAT SCAN / CT
5. Individual Health Assessment
6. Total Cholesterol Screen (4 hour-fasting)
7. Glucose (Blood Sugar) Screen (4 hour-fasting)
8. Body Mass Index screening/calculation
9. CT Scan reviewed by a radiologist and file sent to the patient's primary care provider
10. Consultation with Cardiovascular Specialty RN
11. Consultation with Dietitian optional telephone consult
12. Consultation with Smoking Cessation Specialist optional telephone consult

Avera

Health Plans

Iowa Outline of Coverage

Address:

5300 S. Broadband Lane
Sioux Falls, SD 57108

Toll-Free:

888-322-2115

Hours of operation:

Monday – Friday, 8 a.m. – 5 p.m.



[AveraHealthPlans.com](https://www.AveraHealthPlans.com)