SENATE BILL No. 1203

September 13, 1994, Introduced by Senator PRIDNIA and referred to the Committee on Commerce

A bill to amend sections 3807, 3815, 3823, 3839, and 3857 of Act No 218 of the Public Acts of 1956, entitled as amended "The insurance code of 1956,"

as added by Act No 84 of the Public Acts of 1992, being sections 500 3807, 500 3815, 500 3823, 500 3839, and 500 3857 of the Michigan Compiled Laws

THE PEOPLE OF THE STATE OF MICHIGAN ENACT

Section 1 Sections 3807, 3815, 3823, 3839, and 3857 of Act No 218 of the Public Acts of 1956, as added by Act No 84 of the Public Acts of 1992, being sections 500 3807, 500 3815, 500 3823, 500 3839, and 500 3857 of the Michigan Compiled Laws, are amended to read as follows

Sec 3807 Every insurer issuing a medicare supplement insurance policy in this state shall make available a medicare supplement insurance policy that includes ONLY a basic core

package of benefits to each prospective insured An insurer issuing a medicare supplement insurance policy in this state may make available to prospective insureds benefits pursuant to section 3809 that are in addition to, but not instead of, the basic core package The basic core package of benefits shall include all of the following

(a) Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the 61st day through the 90th day in any medicare benefit period

(b) Coverage of part A medicare eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used

(c) Upon exhaustion of the medicare hospital inpatient coverage including the lifetime reserve days, coverage of the medicare part A eligible expenses for hospitalization paid at the diagnostic related group day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days

(d) Coverage under medicare parts A and B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations unless replaced in accordance with federal regulations

(e) Coverage for the coinsurance amount of medicare eligible expenses under part B regardless of hospital confinement, subject to the medicare part B deductible

Sec 3815 (1) An insurer that offers a medicare supplement policy shall provide to the applicant at the time of application

an outline of coverage and, except for direct response solicitation policies, shall obtain an acknowledgment of receipt of the outline of coverage from the applicant The outline of coverage provided to applicants pursuant to this section shall consist of the following 4 parts

(a) A cover page

(b) Premium information

(c) Disclosure pages

(d) Charts displaying the features of each benefit plan offered by the insurer

(2) IF AN OUTLINE OF COVERAGE IS PROVIDED AT THE TIME OF APPLICATION AND THE MEDICARE SUPPLEMENT POLICY IS ISSUED ON A BASIS THAT WOULD REQUIRE REVISION OF THE OUTLINE, A SUBSTITUTE OUTLINE OF COVERAGE PROPERLY DESCRIBING THE MEDICARE SUPPLEMENT POLICY SHALL ACCOMPANY THE POLICY WHEN IT IS DELIVERED AND SHALL CONTAIN THE FOLLOWING STATEMENT, IN NO LESS THAN 12-POINT TYPE, IMMEDIATELY ABOVE THE COMPANY NAME

NOTICE READ THIS OUTLINE OF COVERAGE CAREFULLY IT IS NOT IDENTICAL TO THE OUTLINE OF COVERAGE PROVIDED UPON APPLICATION AND THE COVERAGE ORIGINALLY APPLIED FOR HAS NOT BEEN ISSUED

(3) ~~(2)~~ An outline of coverage under ~~subsection (1)~~ SUBSECTIONS (1) AND (2) shall be in the language and format prescribed in this section and in not less than 12-point type The A through J letter designation of the plan shall be shown on the cover page and the plans offered by the insurer shall be prominently identified Premium information shall be shown on the cover page or immediately following the cover page and shall be

prominently displayed The premium and method of payment mode shall be stated for all plans that are offered to the applicant All possible premiums for the applicant shall be illustrated The following items shall be included in the outline of coverage in the order prescribed below and in substantially the following form, as approved by the commissioner

(Insurer Name)

Medicare Supplement Coverage

Outline of Medicare Supplement Coverage-Cover Page

Benefit Plan(s)_____ [insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only 10 standard plans This chart shows the benefits included in each plan Every insurer shall make available Plan "A" Some plans may not be available in your state

BASIC BENEFITS Included in All Plans

Hospitalization Part A coinsurance plus coverage for 365 additional days after Medicare benefits end

Medical Expenses Part B coinsurance (20% of Medicare-approved expenses)

Blood First three pints of blood each year

	A	B	C	D	E	F	G	H	I	J
Basic Benefits	x	x	x	x	x	x	x	x	x	x
Skilled Nursing Co-Insurance			x	x	x	x	x	x	x	x
Part A Deductible		x	x	x	x	x	x	x	x	x
Part B Deductible			x			x				x
Part B Excess						x 100%	x 80%		x 100%	x 100%
Foreign Travel Emergency			x	x	x	x	x	x	x	x
At-Home Recovery				x			x		x	x
Drugs								x $1,250 Limit	x $1,250 Limit	x $3,000 Limit
Preventive Care					x					x

PREMIUM INFORMATION

We (insert insurer s name) can only raise your premium if we raise the premium for all policies like yours in this state (If the premium is based on the increasing age of the insured, include information specifying when premiums will change)

DISCLOSURES

Use this outline to compare benefits and premiums among policies, certificates, and contracts

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 your insurance company

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to (insert insurer s address) 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

This policy may not fully cover all of your medical costs

[For agent issued policies]

Neither (insert insurer s name) nor its agents are connected with medicare

[For direct response issued policies]

(Insert insurer s name) is not connected with medicare

This outline of coverage does not give all the details of medicare coverage Contact your local social security office or consult the medicare 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 The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information [If the policy or certificate is guaranteed issue this paragraph need not appear]

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

[Include for each plan offered by the insurer a chart showing the services, medicare payments, plan payments, and insured payments using the same language, in the same order, and using uniform layout and format as shown in the charts that follow An insurer may use additional benefit plan designations on these charts pursuant to section ~~3809(1)(k)~~ 3811(4) Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner The insurer issuing the policy shall change the dollar amounts each year to reflect current figures No more than 4 plans may be shown on 1 chart] Charts for each plan are as follows

PLAN A

MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

*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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$0	$628 (Part A Deductible)
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
--Once lifetime reserve days are used			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78 50 a day	$0	Up to $78 50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN A

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk) your Part B Deductible will have been met for the calendar year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- In or out of the hospital and outpatient hospital treatment, such as Physician's services inpatient and outpatient medical and surgical services and supplies, physical and speech therapy diagnostic tests durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80% (GENERALLY)	20% (GENERALLY)	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-- Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services --Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

*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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
--Once lifetime reserve days are used			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78 50 a day	$0	Up to $78 50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN B

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk) your Part B Deductible will have been met for the calendar year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- In or out of the hospital and outpatient hospital treatment such as Physician s services inpatient and outpatient medical and surgical services and supplies, physical and speech therapy diagnostic tests, durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80% (GENERALLY)	20% (GENERALLY)	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-- Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services --Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

*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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
--Once lifetime reserve days are used			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78 50 a day	Up to $78 50 a day	$0
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN C

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk) your Part B Deductible will have been met for the calendar year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- In or out of the hospital and outpatient hospital treatment, such as Physician s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80% (GENERALLY)	20% (GENERALLY)	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-- Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services --Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL-- Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50 000	20% and amounts over the $50 000 lifetime maximum

PLAN D

MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

*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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
--Once lifetime reserve days are used			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78 50 a day	Up to $78 50 a day	$0
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN D

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk) your Part B Deductible will have been met for the calendar year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- In or out of the hospital and outpatient hospital treatment such as Physician s services inpatient and outpatient medical and surgical services and supplies physical and speech therapy diagnostic tests durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80% (GENERALLY)	20% (GENERALLY)	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-- Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services --Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
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 $40 a 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 not to exceed 7 each week	
--Calendar year maximum	$0	$1 600	

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OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL-- Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50 000	20% and amounts over the $50 000 lifetime maximum

PLAN E

MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

*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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
--Once lifetime reserve days are used			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78 50 a day	Up to $78 50 a day	$0
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN E

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

*Once you have been billed $100 of Medicare-Approved amounts for cover d services (which are noted with an asterisk) your Part B Deductible will have been met for the calendar year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- In or out of the hospital and outpatient hospital treatment such as Physician s services inpatient and outpatient medical and surgical services and supplies physical and speech therapy, diagnostic tests, durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80% (GENERALLY)	20% (GENERALLY)	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-- Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services --Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL-- Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	$0 $0	$0 80% to a lifetime maximum benefit of $50 000	$250 20% and amounts over the $50 000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT-- Not covered by Medicare Annual physical and preventive tests and services such as fecal occult blood test digital rectal exam mammogram hearing screening dipstick urinalysis diabetes screening thyroid function test influenza shot tetanus and diphtheria booster and education			

administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All Costs

PLAN F

MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

*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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
--Once lifetime reserve days are used			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78 50 a day	Up to $78 50 a day	$0
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN F

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk) your Part B Deductible will have been met for the calendar year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- In or out of the hospital and outpatient hospital treatment such as Physician s services inpatient and outpatient medical and surgical services and supplies physical and speech therapy diagnostic tests durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80% (GENERALLY)	20% (GENERALLY)	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-- Blood tests for diagnostic services	100%	$0	$0

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PARTS A & B

HOME HEALTH CARE Medicare Approved Services --Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL-- Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50 000	20% and amounts over the $50 000 lifetime maximum

PLAN G

MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

*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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
--Once lifetime reserve days are used			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78 50 a day	Up to $78 50 a day	$0
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN G

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk) your Part B Deductible will have been met for the calendar year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- In or out of the hospital and outpatient hospital treatment such as Physician s services inpatient and outpatient medical and surgical services and supplies physical and speech therapy diagnostic tests durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80% (GENERALLY)	20% (GENERALLY)	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-- Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services --Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
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 $40 a 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 not to exceed 7 each week	
--Calendar year maximum	$0	$1 600	

(continued)

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL-- Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50 000 lifetime maximum

PLAN H

MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

*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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
--Once lifetime reserve days are used			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All bu $78 50 a day	Up to $78 50 a day	$0
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN H

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk) your Part B Deductible will have been met for the calendar year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80% (GENERALLY)	20% (GENERALLY)	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-- Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services --Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL-- Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50 000	20% and amounts over the $50 000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS-- Not covered by Medicare First $250 each calendar year	$0	$0	$250
Next $2 500 each calendar year	$0	50%--$1 250 calendar year maximum benefit	50%
Over $2 500 each calendar year	$0	$0	All Costs

PLAN I

MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

*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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
--Once lifetime reserve days are used			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78 50 a day	Up to $78 50 a day	$0
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN I

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk) your Part B Deductible will have been met for the calendar year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy diagnostic tests durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80% (GENERALLY)	20% (GENERALLY)	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-- Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services --Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
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			Balance
--Benefit for each visit	$0	Actual Charges to $40 a visit	
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits not to exceed 7 each week	
--Calendar year maximum	$0	$1 600	

(continued)

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL-- Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges*	$0	80% to a lifetime maximum benefit of $50 000	20% and amounts over the $50 000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS-- Not covered by Medicare			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%--$1 250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

PLAN J

MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

*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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
--Once lifetime reserve days are used			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78 50 a day	Up to $78 50 a day	$0
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN J

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk) your Part B Deductible will have been met for the calendar year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- In or out of the hospital and outpatient hospital treatment such as Physician s services inpatient and outpatient medical and surgical services and supplies, physical and speech therapy diagnostic tests durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80% (GENERALLY)	20% (GENERALLY)	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-- Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services --Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-- Not covered by Medicare Home care certified by your doctor for personal care beginning during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan --Benefit for each visit	$0	Actual Charges to $40 a 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 not to exceed 7 each week	
--Calendar year maximum	$0	$1 600	

(continued)

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL-- Not covered by Medicare gency care services begin- ning during the first 60 days of each trip outside the USA			
First $250 each calen- dar year	$0	$0	$250
Remainder of Charges	$0	80% to a life- time maximum benefit of $50 000	20% and amounts over the $50 000 lifetime maximum
EXTENDED OUTPATIENT PRE- SCRIPTION DRUGS-- Not covered by Medicare			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50%--$3 000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All Costs
PREVENTIVE MEDICAL CARE BENEFIT-- Not covered by Medicare Annual physical and pre- ventive tests and services such as fecal occult blood test digital rectal exam mammogram hearing screening dipstick urinalysis diabetes screening thyroid func- tion test influenza shot tetanus and diphtheria booster and education administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

Sec 3823 An insurance policy shall not be titled advertised solicited or issued for delivery in this state as a medicare supplement policy unless the definitions and terms contained in the policy are such that covered benefits under the policy are not more restrictive than covered benefits under medicare and those required to be provided under state law A MEDICARE SUPPLEMENT POLICY SHALL CONTAIN A DEFINITION OF MEDICARE AS THAT TERM IS DEFINED IN SECTION 3801 OR SUBSTANTIALLY SIMILAR TO THAT DEFINITION

Sec 3839 (1) Each medicare supplement policy shall include a renewal or continuation provision The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the term of coverage for which the policy is issued and for which it may be renewed The provision shall include any reservation by the insurer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age

(2) If a medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subsection (4), the issuer shall offer certificate holders an individual medicare supplement policy that at the option of the certificate holder provides for conti uation of the benefits contained in the group policy or provides for such benefits as otherwise meet the requirements of section 3819

(3) If an individual is a certificate holder in a group medicare supplement policy and the individual terminates membership in the group the issuer shall offer the certificate

holder the conversion opportunity described in subsection ~~(4)~~ (2) or at the option of the group policyholder offer the certificate holder continuation of coverage under the group policy

(4) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced

Sec 3857 (1) An insurer shall do all of the following

(a) Accept a notice from a medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and make a payment determination on the basis of the information contained in that notice

(b) Notify the participating physician or supplier and the beneficiary of the payment determination

(c) Pay the participating physician or supplier directly

(d) Furnish at the time of enrollment each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a medicare carrier may be sent

(e) Pay user fees for claim notices that are transmitted electronically or otherwise

(f) Provide to the secretary of health and human services at least annually, a central mailing address to which all claims may be sent by medicare carriers

(2) Compliance with the requirements set forth in subsection ~~(1)(a)~~ (1) shall be certified on the medicare supplement insurance experience reporting form