

# **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

- 1 Section 1 Sections 3807, 3815, 3823, 3839, and 3857 of Act
- 2 No 218 of the Public Acts of 1956, as added by Act No 84 of the
- 3 Public Acts of 1992, being sections 500 3807, 500 3815, 500 3823,
- 4 500 3839, and 500 3857 of the Michigan Compiled Laws, are amended
- 5 to read as follows
- 6 Sec 3807 Every insurer issuing a medicare supplement
- 7 insurance policy in this state shall make available a medicare
- 8 supplement insurance policy that includes ONLY a basic core

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- 1 package of benefits to each prospective insured An insurer
- 2 issuing a medicare supplement insurance policy in this state may
- 3 make available to prospective insureds benefits pursuant to
- 4 section 3809 that are in addition to, but not instead of, the
- 5 basic core package The basic core package of benefits shall
- 6 include all of the following
- 7 (a) Coverage of part A medicare eligible expenses for hospi-
- 8 talization to the extent not covered by medicare from the 61st
- 9 day through the 90th day in any medicare benefit period
- 10 (b) Coverage of part A medicare eliquble expenses incurred
- 11 for hospitalization to the extent not covered by medicare for
- 12 each medicare lifetime inpatient reserve day used
- 13 (c) Upon exhaustion of the medicare hospital inpatient cov-
- 14 erage including the lifetime reserve days, coverage of the medi-
- 15 care part A eligible expenses for hospitalization paid at the
- 16 diagnostic related group day outlier per diem or other appropri-
- 17 ate standard of payment, subject to a lifetime maximum benefit of
- 18 an additional 365 days
- 19 (d) Coverage under medicare parts A and B for the reasonable
- 20 cost of the first 3 pints of blood or equivalent quantities of
- 21 packed red blood cells, as defined under federal regulations
- 22 unless replaced in accordance with federal regulations
- (e) Coverage for the coinsurance amount of medicare eligible
- 24 expenses under part B regardless of hospital confinement, subject
- 25 to the medicare part B deductible
- 26 Sec 3815 (1) An insurer that offers a medicare supplement
- 27 policy shall provide to the applicant at the time of application

- 1 an outline of coverage and, except for direct response
- 2 solicitation policies, shall obtain an acknowledgment of receipt
- 3 of the outline of coverage from the applicant The outline of
- 4 coverage provided to applicants pursuant to this section shall
- 5 consist of the following 4 parts
- 6 (a) A cover page
- 7 (b) Premium information
- 8 (c) Disclosure pages
- 9 (d) Charts displaying the features of each benefit plan
- 10 offered by the insurer
- 11 (2) IF AN OUTLINE OF COVERAGE IS PROVIDED AT THE TIME OF
- 12 APPLICATION AND THE MEDICARE SUPPLEMENT POLICY IS ISSUED ON A
- 13 BASIS THAT WOULD REQUIRE REVISION OF THE OUTLINE, A SUBSTITUTE
- 14 OUTLINE OF COVERAGE PROPERLY DESCRIBING THE MEDICARE SUPPLEMENT
- 15 POLICY SHALL ACCOMPANY THE POLICY WHEN IT IS DELIVERED AND SHALL
- 16 CONTAIN THE FOLLOWING STATEMENT, IN NO LESS THAN 12-POINT TYPE,
- 17 IMMEDIATELY ABOVE THE COMPANY NAME
- 18 NOTICE READ THIS OUTLINE OF COVERAGE CAREFULLY IT IS NOT
- 19 IDENTICAL TO THE OUTLINE OF COVERAGE PROVIDED UPON APPLICATION
- 20 AND THE COVERAGE ORIGINALLY APPLIED FOR HAS NOT BEEN ISSUED
- 21 (3) -(2) An outline of coverage under -subsection (1)
- 22 SUBSECTIONS (1) AND (2) shall be in the language and format pre-
- 23 scribed in this section and in not less than 12-point type The
- 24 A through J letter designation of the plan shall be shown on the
- 25 cover page and the plans offered by the insurer shall be promi-
- 26 nently identified Premium information shall be shown on the
- 27 cover page or immediately following the cover page and shall be

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

1	(Insurer Name)										
2											
3											
4	Benefit Plan(s) [insert letter(s) of plan(s) being offered]										
5	Medicare supplement	ingu	rance	can be	ബർ	in onl	v 10 sta	andard p	lans This	s chart sh	nows the
	benefits included:										
	may not be available				, TIBU	ICI DI	ALL MAN	- uvuzzu	220 1 200.		P-G-C
				ll Plan	c						
	Hospitalization Pa					overac	e for 3	65 addit	ional days	s after Mo	edicare
	benefits end	<b>42 C</b>	· · · · · ·	1100	Prub o	0,0149	,				
-	Medical Expenses	Part B	coins	urance	(20%	of Med	licare-a	poroved	expenses)		
	Blood First three							PPIONOL	J.,		
13	22004 12120 41100	P200	02 22		, <sub>1</sub>	_					
14		A	В	TC	D	E	F	G	H	I	J
15			•	•		•	•	,	•	•	•
16	Basic Benefits	х	х	х	х	х	х	x	х	х	x
17		•	•	•	•	•	•	•	·	·	·
18	Skilled Nursing										
19	Co-Insurance		}	х	x	x	x	x	x	x	x
20											
21	Part A Deductible		X	x	x	x	X	x	x	x	x
22			·•			<b>.</b>				<del></del>	
23	Part B Deductible		1	X	1	ł	X		1	1	) x
24		<del></del>	·		<del>,                                     </del>	<del></del>		<del></del>	<del></del>	<del></del>	<del></del>
	Part B Excess				1	į	X	X		X LOOS	X
26		ł	1	1	1	1	100%	80%	1	100%	100%
27	Foreign Travel	1	<del></del>	<del></del>	1	<del></del>	<del>                                     </del>		<del></del>		<del></del>
	Emergency	1		×	x	×	x	x	x	x	×
30		J	1	1 ^	1 ^	1 ^	1 4	1 ^	1 4	, ~	1 ^
31		T	<del>1</del>	1	X	<del>                                     </del>	7	x		х	х
32		U	•	•	,	•	•	•	•	•	
33		1	T		1	T-	<del></del>		х	х	х
34	Drugs	1	Į		1	1	1	1	\$1,250	\$1,250	\$3,000
35	_	}		1		ŀ		1	Limit	Limit	Limit
36		•	•	-		•	•	•	•	•	•
37	Preventive Care	1	1	1		х				1	x
38	1	•	•	•	•	•	•	•	•	•	•

### 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 pre-4 mium is based on the increasing age of the insured, include information specifying when premiums will change)

DISCLOSURES

7 Use this outline to compare benefits and premiums among policies, 8 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 land your insurance company.

14 RIGHT TO RETURN POLICY

15 If you find that you are not satisfied with your policy, you may
16 return it to (insert insurer's address) If you send the policy back
17 to us within 30 days after you receive it, we will treat the policy
18 as if it had never been issued and return all of your payments
19 POLICY REPLACEMENT

20 If you are replacing another health insurance policy, do not 21 cancel it until you have actually received your new policy and are 22 sure you want to keep it

23 NOTICE

- 24 This policy may not fully cover all of your medical costs
- 25 [For agent issued policies]
- 26 Neither (insert insurer s name) nor its agents are connected with 27 medicare
- 28 [For direct response issued policies]
- 29 (Insert insurer s name) is not connected with medicare
- 30 This outline of coverage does not give all the details of medicare
- 31 coverage Contact your local social security office or consult the
- 32 medicare handbook for more details
- 33 COMPLETE ANSWERS ARE VERY IMPORTANT
- 34 When you fill out the application for the new policy be sure to
- 35 answer truthfully and completely all questions about your medical and
- 36 health history The company may cancel your policy and refuse to pay
- 37 any claims if you leave out or falsify important medical information
- 38 [If the policy or certificate is guaranteed issue this paragraph
- 39 need not appear ]

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1 Review the application carefully before you sign it Be certain 2 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  $\frac{3609(1)(k)}{38!!(4)}$  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.

1 PLAN A

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

7	row			
8 9 10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
13 14	HOSPITALIZATION* Semiprivate room and board general nursing and mis- cellaneous services and			
16 17 18	supplies First 60 days	All but \$628	\$0	\$628 (Part A Deductible)
19 20 21	61st thru 90th day 91st day and afterWhile using 60 lifetime	All but \$157 a day	\$157 a day	\$0
22 23	reserve daysOnce lifetime reserve	All but \$314 a day	\$314 a day	\$0
24 25 26 27 28	days are used Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
29 30 31	Beyond the Additional 365 days	\$0	\$0	All Costs
34 35 36 37 38 39 40	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  21st thru 100th day 101st day and after	All approved amounts All but \$78 50 a day \$0	\$0 \$0 \$0	\$0 Up to \$78 50 a day All costs
47 48				
50	BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

1		-	
3 HOSPICE CARE 4 Available as long as your 5 doctor certifies you are 6 terminally ill and you 7 elect to receive these 8 services 9	All but very limited coinsurance for outpatient drugs and inpatient respite care		Balance

PLAN A

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR 3 \*Once you have been billed \$100 of Medicare-Approved amounts for covered 4 services (which are noted with an asterisk) your Part B Deductible will

5 have been met for the calendar year

1

2

6						
7 8 9	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY		
13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28	MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment, such as Physi- cian's services inpatient and outpatient medical and surgical services and sup- plies, physical and speech therapy diagnostic tests durable medical equipment First \$100 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 80% (GENERALLY) \$0	\$0 20% (GENERALLY) \$0	\$100 (Part B Deductible) \$0 All Costs		
32	BLOOD First 3 pints	\$0	All Costs	\$0		
34 35	Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)		
36 37 38	Remainder of Medicare Approved Amounts	80%	20%	\$0		
41 42	CLINICAL LABORATORY SERVICES Blood tests for diagnostic	1000				
43 44	services	100%	\$0	\$0		

PARTS A & B				
	HOME HEALTH CARE Medicare Approved Services			
7 8 9 10	Medically necessary skilled care services and medical suppliesDurable medical equip- ment	100%	\$0	\$0
12 13 14	First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
15 16 17	Remainder of Medicare Approved Amounts	80%	20%	\$0

1 PLAN B

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

7				
8 9 10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
13 14 15	HOSPITALIZATION* Semiprivate room and board general nursing and mis- cellaneous services and			
16 17 18 19	supplies First 60 days	All but \$628	\$628 (Part A Deductible)	\$0
20 21 22	61st thru 90th day 91st day and after While using 60 lifetime	All but \$157 a day	\$157 a day	\$0
23 24 25	reserve daysOnce lifetime reserve days are used	All but \$314 a day	\$314 a day	\$0
26 27 28 29	Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
30 31 32	Beyond the Additional 365 days	\$0	\$0	All Costs
35 36 37 38 39 40 41	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			
43 44 45 46 47	First 20 days  21st thru 100th day  101st day and after	All approved amounts All but \$78 50 a day \$0	\$0 \$0 \$0	\$0 Up to \$78 50 a day All costs
51	BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

1				
2				
3	HOSPICE CARE			
4	Available as long as your	All but very	\$0	Balance
5	doctor certifies you are	limited coinsurance		
	terminally ill and you	for outpatient		
	elect to receive these	drugs and inpatient		
8	services	respite care		
9				·

PLAN B

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

3 \*Once you have been billed \$100 of Medicare-Approved amounts for covered 4 services (which are noted with an asterisk) your Part B Deductible will 5 have been met for the calendar year

6				
7 8 9	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35	MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment such as Physi- cian s services inpatient and outpatient medical and surgical services and sup- plies, physical and speech therapy diagnostic tests, durable medical equipment First \$100 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 80% (GENERALLY)	\$0 20% (GENERALLY) \$0	\$100 (Part B Deductible) \$0 All Costs
	BLOOD First 3 pints Next \$100 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$100 (Part B Deductible)
39 40 41	CLINICAL LABORATORY SERVICES Blood tests for diagnostic services	100%	\$0	\$0

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1 2				
3 4 5 6 7 8 9 10	HOME HEALTH CARE Medicare Approved ServicesMedically necessary skilled care services and medical suppliesDurable medical equip- ment	100%	\$0	\$0
12 13 14 15 16	First \$100 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0 80%	\$0	\$100 (Part B Deductible)

1 PLAN C

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

7				
8 9 10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
13 14 15	HOSPITALIZATION* Semiprivate room and board general nursing and miscellaneous services and supplies			
17 18 19	First 60 days	All but \$628	\$628 (Part A Deductible)	\$0
20 21 22	61st thru 90th day 91st day and afterWhile using 60 lifetime	All but \$157 a day	\$157 a day	\$0
23 24 25	reserve daysOnce lifetime reserve days are used	All but \$314 a day	\$314 a day	\$0
26 27 28 29 30	Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
31 32	Beyond the Additional 365 days	\$0	\$0	All Costs
33 34 35 36 37 38 39 40 41	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  21st thru 100th day  101st day and after	All approved amounts All but \$78 50 a day	\$0 Up to \$78 50 a day \$0	\$0 \$0 All costs
40	ivist day and after	ŞU	şυ (	WII CODED

4	BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
9 10 11 12	HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but ver limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

1 PLAN C

2 MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR
3 \*Once you have been billed \$100 of Medicare-Approved amounts for cov

3 \*Once you have been billed \$100 of Medicare-Approved amounts for covered 4 services (which are noted with an asterisk) your Part B Deductible will 5 have been met for the calendar year

7 8 9	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY	
10 11 12 13 14 15 16 17 18 19 20 21 22 22 22 22 22 22 22 22 22 22 22 22	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*  Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 80% (GENERALLY) \$0	\$100 (Part B Deductible) 20% (GENERALLY) \$0	\$0 \$0 All Costs	
32 33	BLOOD First 3 pints Next \$100 of Medicare	\$0	All Costs	\$0	
34 35 36 37	Approved Amounts*  Remainder of Medicare  Approved Amounts	\$0  80%	\$100 (Part B  Deductible)     20%	\$0 \$0	

# PARTS A & B

1 2		PARTS A & B				
3 4 5 6 7 8 9	HOME HEALTH CARE Medicare Approved ServicesMedically necessary skilled care services and medical suppliesDurable medical equip-	100%	\$0	\$0		
11 12 13 14 15	ment First \$100 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0 80%	\$100 (Part B Deductible)	\$0  \$0		
17 18 19 20						
23 24 25 26 27	FOREIGN TRAVEL Not covered by Medicare Medically necessary emer- gency care services begin- ning 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 life- time maximum benefit of \$50 000	\$250 20% and amounts over the \$50 000 lifetime maximum		

1 PLAN D

2 MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BLNEFIT PERIOD

7					
8 9 10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY	
13 14 15	HOSPITALIZATION* Semiprivate room and board, general nursing and mis- cellaneous services and supplies				
17 18 19	First 60 days	All but \$628	\$628 (Part A Deductible)	\$0	
20 21 22	61st thru 90th day 91st day and afterWhile using 60 lifetime	All but \$157 a day	\$157 a day	\$0	
23 24 25	reserve daysOnce lifetime reserve days are used	All but \$314 a day	\$314 a day	\$0	
26 27 28 29	Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0	
30 31 32	Beyond the Additional 365 days	\$0	\$0	All Costs	
35 36 37 38 39 40 41	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  21st thru 100th day	All approved amounts All but \$78 50 a day	\$0 Up to \$78 50 a day	\$0 \$0	
48	101st day and after	\$0	\$0	All costs	

1				•	_
4	BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 <b>\$0</b>	_
9 10 11 12	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

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2

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

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

6				
7 8 9	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29	MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment such as Physi- cian s services inpatient and outpatient medical and surgical services and sup- plies physical and speech therapy diagnostic tests durable medical equipment First \$100 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 80% (GENERALLY) \$0	\$0 20% (GENERALLY)	\$100 (Part B Deductible) \$0 All Costs
32 33 34 35	BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$100 (Part B Deductible)
39 40 41	CLINICAL LABORATORY SERVICES Blood tests for diagnostic services	100%	\$0	\$0

PARTS	Δ	r.	В

1 2				
3 4 5	HOME HEALTH CARE Medicare Approved			
6 7 8	ServicesMedically necessary skilled care services			
9	and medical suppliesDurable medical equip-	100%	\$0	\$0
11 12	ment First \$100 of Medicare			
13	Approved Amounts*	\$0	\$0	\$100 (Part B  Deductible)
-	Remainder of Medicare Approved Amounts AT-HOME RECOVERY SERV-	80%	20%	\$0
19 20	VICES Not covered by Medicare Home care certi-			
22	fied by your doctor, for personal care during recovery from an injury			
24 25	or sickness for which Medicare approved a Home			
27 28	Care Treatment PlanBenefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
29 30 31	Number of visits covered (must be			
32	received within 8 weeks of last Medi-			
33 34 35 36 37 38	care Approved visit)	\$0	Up to the num- ber of Medicare Approved visits not to exceed 7 each	
39 40	Calendar year maxımum	\$0	week  \$1 600	

#### OTHER BENEFITS -- NOT COVERED BY MEDICARE 2 3 4 FOREIGN TRAVEL--5 Not covered by Medicare 6 Medically necessary emer-7 gency care services 8 beginning during the 9 first 60 days of each 10 trip outside the USA First \$250 each 11 calendar year Remainder of charges 12 \$0 **\$**0 \$250 13 20% and \$0 80% to a life-14 time maximum amounts over 15 benefit of the \$50 000 16 \$50 000 lifetime 17 maxımum 18

PLAN E

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

7					
8 9 10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY	
13 14 15	HOSPITALIZATION* Semiprivate room and board general nursing and mis- cellaneous services and supplies				
17 18 19	First 60 days	All but \$628	\$628 (Part A Deductible)	\$0	
20 21 22	<pre>61st thru 90th day 91st day and afterWhile using 60 lifetime</pre>	All but \$157 a day	\$157 a day	\$0	
23 24 25	reserve daysOnce lifetime reserve days are used	All but \$314 a day	\$314 a day	\$0	
26 27 28 29	Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0	
30 31 32 33	Beyond the Additional 365 days	\$0	\$0	All Costs	
34	SKILLED NURSING FACILITY CARE*				
36 37 38 39 40 41	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				
43 44 45 46	First 20 days 21st thru 100th day	All approved amounts All but \$78 50 a day	\$0 Up to \$78 50	\$0 \$0	
47 48	101st day and after	\$0	a day \$0	All costs	

4	BLOOD First 3 pints Additional amounts	\$0 100%	3 pints	\$0 \$0
9 10 11 12	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

1 PLAN E MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR 2

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4 \*Once you have been billed \$100 of Medicare-Approved amounts for cover 3 services (which are noted with an asterisk) your Part B Deductible Will 6 have been met for the calendar year

7	<u> </u>			
8 9 10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30	MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment such as Physi- cian's services inpatient and outpatient medical and surgical services and sup- plies physical and speech therapy, diagnostic tests, durable medical equipment First \$100 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 80% (GENERALLY) \$0	\$0 20% (GENERALLY) \$0	\$100 (Part B Deductible) \$0 All Costs
33 34 35 36	BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
40 41 42	CLINICAL LABORATORY SERVICES Blood tests for diagnostic services	100%	\$0	\$0

1	PARTS A & B				
2 3 4 5 6 7 8 9	HOME HEALTH CARE Medicare Approved ServicesMedically necessary skilled care services and medical suppliesDurable medical equip-	100%	\$0	\$0	
11 12 13 14	ment First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)	
15 16 17	Remainder of Medicare Approved Amounts	80%	20%	\$0	
18 19 20 21 22	OTHER BENEFITSNOT COVERED BY MEDICARE				
23 24 25 26 27 28 29 30 31 32 33 34 35 36 37	FOREIGN TRAVEL Not covered by Medicare Medically necessary emer- gency 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 life- time maximum benefit of \$50 000	\$250 20% and amounts over the \$50 000 lifetime maximum	
38 39 40 41 42 43 44 45 46 47 48 49 50 51	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				

		29		
2	administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges	\$0 \$0	\$120  \$0	\$0 All Costs

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1 PLAN F

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

SERVICES HOSPITALIZATION*	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSDITALITATION*			
Semiprivate room and board general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and afterWhile using 60 lifetime reserve daysOnce lifetime reserve days are usedAdditional 365 days	All but \$628  All but \$157 a day  All but \$314 a day  \$0	\$628 (Part A Deductible) \$157 a day \$314 a day 100% of Medicare Eliqible	\$0 \$0 \$0 \$0
Beyond the Additional 365 days	\$0	Expenses	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  21st thru 100th day	All approved amounts All but \$78 50 a day	\$0 Up to \$78 50 a day \$0	\$0 \$0 All costs
	general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and afterWhile using 60 lifetime reserve daysOnce lifetime reserve days are usedAdditional 365 days Beyond the Additional 365 days  SKILLED NURSING FACILITY CARE* You must meet Medicare sequirements including the nospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days  21st thru 100th day	General nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and afterWhile using 60 lifetime reserve daysOnce lifetime reserve days are usedAdditional 365 days  68kILLED NURSING FACILITY CARE*  Cou must meet Medicare sequirements including laving been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days  fifter leaving the hospital First 20 days  21st thru 100th day  All but \$157 a day  All but \$314 a day	general nursing and miscal laneous services and supplies First 60 days  All but \$628  (Part A Deductible)  All but \$157 a day  91st day and after While using 60 lifetime reserve daysOnce lifetime reserve days are used Additional 365 days  All but \$157 a day  \$314 a day  \$314 a day  \$314 a day  \$316 a day  \$315 a day  \$315 a day  \$316 a day  \$318 a day  \$3

	OOD rst 3 pints ditional amounts	\$0 100%	3 pints \$0	\$0 \$0
9 Ava 10 doo 11 ter	SPICE CARE allable as long as your ctor certifies you are rminally ill and you ect to receive these rvices	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

PLAN F

1

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

3 \*Once you have been billed \$100 of Medicare-Approved amounts for covered 4 services (which are noted with an asterisk) your Part B Deductible will 5 have been met for the calendar year

6					
7 8 9	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY	
10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 27 28	Approved Amounts Part B Excess Charges	\$0 80% (GENERALLY) \$0	\$100 (Part B Deductible) 20% (GENERALLY)	\$0 \$0 \$0	
32 33 34 35 36 37 38	BLOOD First 3 pints Next \$100 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0 \$0 80%	Ail Costs \$100 (Part B Deductible) 20%	\$0 \$0 \$0	
41	CLINICAL LABORATORY SERVICES Blood tests for diagnostic services	100%	\$0	\$0	

## PARTS A & B

2				
3 4 5 6 7 8 9	HOME HEALTH CARE Medicare Approved ServicesMedically necessary skilled care services and medical suppliesDurable medical equip-	100%	\$0	\$0
11 12 13 14 15 16	ment First \$100 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0 80%	\$100 (Part B Deductible)	\$0 \$0
17 18 19 20 21 22	OTHER BENEFITSNOT COVERED BY MEDICARE  FOREIGN TRAVEL			
23 24 25 26 27	Not covered by Medicare Medically necessary emer- gency care services begin- ning during the first 60	\$0 \$0	\$0 80% to a life- time maximum benefit of \$50 000	\$250 20% and amounts over the \$50 000 lifetime maximum

1

PLAN G

1

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

7				
8 9 10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
13 14 15	HOSPITALIZATION* Semiprivate room and board general nursing and mis- cellaneous services and			
16 17 18 19	supplies First 60 days	All but \$628	\$628 (Part A Deductible)	\$0
20 21 22	61st thru 90th day 91st day and after While using 60 lifetime	All but \$157 a day	\$157 a day	\$0
23 24 25	reserve daysOnce lifetime reserve days are used	All but \$314 a day	\$314 a day	\$0
26 27 28 29	Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
30 31 32	Beyond the Additional 365 days	\$0	\$0	All Costs
35	SKILLED NURSING FACILITY CARE* You must meet Medicare s			
37 38 39 40 41	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			
43 44 45 46	First 20 days 21st thru 100th day	All approved amounts All but \$78 50 a day	\$0 Up to \$78 50	\$0 \$0
47 48	101st day and after	\$0	a day \$0	All costs

4	BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
9 10 11 12	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

1 2 MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

3 \*Once you have been billed \$100 of Medicare-Approved amounts for covered 4 services (which are noted with an asterisk) your Part B Deductible will 5 have been met for the calendar year

6			· · · · · · · · · · · · · · · · · · ·	4
7 8 9	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
13 14 15 16 17 18 19 20	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			
21 22 23	First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
24 25 26 27	Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare	80% (GENERALLY)	20% (GENERALLY)	\$0
28 29	Approved Amounts)	\$0	80%	20%
	BLOOD			
	First 3 pints Next \$100 of Medicare	\$0	All Costs	\$0
34 35	Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
37 38	Remainder of Medicare Approved Amounts	80%	20%	\$0
39 40 41	CLINICAL LABORATORY SERVICES			
42 43 44	Blood tests for diagnostic services	100%	\$0	\$0

PARTS A & B

1 2		PARTS A & B		
3				
	HOME HEALTH CARE			
5	Medicare Approved			
6	<del>-</del> -	}		
7	Medically necessary			
8	skilled care services	}		
9	and medical supplies	100%	\$0	\$0
10	Durable medical equip-			
11	ment			
12	First \$100 of Medicare			0100 (Damb D
13	Approved Amounts*	\$0	\$0	\$100 (Part B
14		1		Deductible)
15	Remainder of Medicare	000	208	\$0
16	Approved Amounts	80%	20%	\$0
_	AT-HOME RECOVERY SERV- VICES			
	Not covered by Medicare			
	Home care certi-			
	fied by your doctor, for			
22	personal care during			
	recovery from an injury			
	or sickness for which			
	Medicare approved a Home			
	Care Treatment Plan			
27	Benefit for each visit	\$0	Actual Charges	
28			to \$40 a visit	Balance
29	Number of visits			
30	covered (must be			
31	received within 8			
32	weeks of last Med1-			
33	<pre>care Approved visit)</pre>	\$0	Up to the num-	
34			ber of Medicare	
35 36			Approved visits not to	
30 37			exceed 7 each	
38			week	
39	Calendar year maxımum	\$0	\$1 600	
40	caremat year maximum	1 🕶	<del>                                    </del>	
-				

1	OTHER BENE			
5 6 7 8 9	Remainder of charges	\$0 \$0	\$0 80% to a life- time maximum benefit of \$50,000	\$250 20% and amounts over the \$50 000 lifetime maximum

PLAN H

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

3 \*A benefit period begins on the first day you receive service as an inpa-4 tient in a hospital and ends after you have been out of the hospital and 5 have not received skilled care in any other facility for 60 days in a 6 row

7				
8 9 10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
11 12 13 14 15	HOSPITALIZATION* Semiprivate room and board general nursing and miscellaneous services and supplies			
17 18 19	First 60 days	All but \$628	\$628 (Part A Deductible)	\$0
20 21 22	61st thru 90th day 91st day and after While using 60 lifetime	All but \$157 a day	\$157 a day	\$0
23 24 25	reserve daysOnce lifetime reserve days are used	All but \$314 a day	\$314 a day	\$0
26 27 28 29	Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
30 31 32	Beyond the Additional 365 days	\$0	\$0	All Costs
35 36 37 38 39 40 41	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	\$0	<b>\$</b> 0
45 46 47	21st thru 100th day	All bu \$78 50 a day	Up to \$78 50 a day	\$0
48	101st day and after	\$0	\$0	All costs

1

4	BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
9 10 11 12	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

1 PLAN H

2

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

4 \*Once you have been billed \$100 of Medicare-Approved amounts for covered 5 services (which are noted with an asterisk) your Part B Deductible will 6 have been met for the calendar year

8 9 SERVICES 0	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES  In or out of the hospital and outpatient hospital treatment, such as Physi- cian's services, inpatient and outpatient medical and surgical services and sup- plies, physical and speech therapy, diagnostic tests, durable medical equipment First \$100 of Medicare Approved Amounts*  Remainder of Medicare	\$0	\$0	\$100 (Part B Deductible)
Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	80% (GENERALLY)	20% (GENERALLY)	\$0 All Costs
1			
2 BLOOD 3 First 3 pints 4 Next \$100 of Medicare	\$0	All Costs	\$0
5 Approved Amounts* 6	\$0	\$0	\$100 (Part B Deductible)
7 Remainder of Medicare 8 Approved Amounts 9	80%	20%	\$0
0 1 CLINICAL LABORATORY 2 SERVICES			
3 Blood tests for diagnostic 4 services 5	100%	\$0	\$0

	PARTS A & B		
HOME HEALTH CARE			
Medicare Approved			
Services			
Medically necessary			
skilled care services			
and medical supplies	100%	\$0	\$0
Durable medical equip-			
ment			
First \$100 of Medicare			4.00 (8
Approved Amounts*	\$0	\$0	\$100 (Part
			Deductible
Remainder of Medicare			
Approved Amounts	180%	20%	\$0
OTHER BENE	FITSNOT COVERE	D BY MEDICARE	
FOREIGN TRAVEL			
Not covered by Medicare		1	
Medically necessary emer-			
gency care services	İ		
beginning during the first			
60 days of each trip outside the USA			
First \$250 each			
riist \$250 Each		co	\$250
galondar woar	ien		
calendar year	\$0	\$0  80% to a life-	I •
calendar year Remainder of Charges	\$0 \$0	80% to a life-	20% and
		80% to a life- time maximum	20% and amounts ov
		80% to a life- time maximum benefit of	20% and amounts ov
		80% to a life- time maximum	20% and amounts over the \$50 00
		80% to a life- time maximum benefit of	20% and amounts over the \$50 00 lifetime
		80% to a life- time maximum benefit of	20% and amounts over the \$50 00 lifetime
Remainder of Charges		80% to a life- time maximum benefit of	20% and amounts over the \$50 00 lifetime
Remainder of Charges  BASIC OUTPATIENT PRE-		80% to a life- time maximum benefit of	20% and amounts over the \$50 00 lifetime
Remainder of Charges  BASIC OUTPATIENT PRE- SCRIPTION DRUGS		80% to a life- time maximum benefit of \$50 000	20% and amounts over the \$50 00 lifetime maximum
Remainder of Charges  BASIC OUTPATIENT PRE- SCRIPTION DRUGS Not covered by Medicare		80% to a life- time maximum benefit of	20% and amounts over the \$50 00 lifetime
Remainder of Charges  BASIC OUTPATIENT PRE- SCRIPTION DRUGS Not covered by Medicare First \$250 each	\$0	80% to a life- time maximum benefit of \$50 000	20% and amounts over the \$50 00 lifetime maximum
Remainder of Charges  BASIC OUTPATIENT PRE- SCRIPTION DRUGS Not covered by Medicare First \$250 each calendar year	\$0	80% to a life- time maximum benefit of \$50 000	20% and amounts over the \$50 00 lifetime maximum
Remainder of Charges  BASIC OUTPATIENT PRE- SCRIPTION DRUGS Not covered by Medicare First \$250 each calendar year Next \$2 500 each	\$0	80% to a life- time maximum benefit of \$50 000	20% and amounts over the \$50 00 lifetime maximum
Remainder of Charges  BASIC OUTPATIENT PRE- SCRIPTION DRUGS Not covered by Medicare First \$250 each calendar year Next \$2 500 each	\$0	80% to a life- time maximum benefit of \$50 000	20% and amounts over the \$50 00 lifetime maximum
Remainder of Charges  BASIC OUTPATIENT PRE- SCRIPTION DRUGS Not covered by Medicare First \$250 each calendar year Next \$2 500 each	\$0	80% to a life- time maximum benefit of \$50 000  \$0  50%\$1 250 calendar year	20% and amounts over the \$50 00 lifetime maximum
Remainder of Charges  BASIC OUTPATIENT PRE- SCRIPTION DRUGS Not covered by Medicare First \$250 each calendar year Next \$2 500 each calendar year	\$0	80% to a life- time maximum benefit of \$50 000  \$0  50%\$1 250 calendar year	20% and amounts over the \$50 00 lifetime maximum

PLAN I

1

2

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

3 \*A benefit period begins on the first day you receive service as an inpa-4 tient in a hospital and ends after you have been out of the hospital and 5 have not received skilled care in any other facility for 60 days in a 6 row

7				
8 9 10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
13 14 15 16	<b>-</b>			
17 18 19	First 60 days	All but \$628	\$628  (Part A  Deductible)	\$0
20 21 22	61st thru 90th day 91st day and afterWhile using 60 lifetime	All but \$157 a day	\$157 a day	\$0
23 24 25	reserve daysOnce lifetime reserve days are used	All but \$314 a day	\$314 a day	\$0
26 27 28 29	Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
30 31 32	Beyond the Additional 365 days	\$0	\$0	All Costs
35 36 37 38 39 40 41 42 43 44 45 46 47	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  21st thru 100th day	All approved amounts All but \$78 50 a day	\$0 Up to \$78 50 a day	\$0 \$0
48	101st day and after	\$0	\$0	All costs

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

PLAN I

1

2

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

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

6				
7 8 9	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29	MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment, such as Physi- cian's services, inpatient and outpatient medical and surgical services and sup- plies, physical and speech therapy diagnostic tests durable medical equipment, First \$100 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 80% (GENERALLY) \$0	\$0 20% (GENERALLY)	\$100 (Part B Deductible) \$0
32 33 34 35	BLOOD First 3 pints Next \$100 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
41	CLINICAL LABORATORY SERVICES Blood tests for diagnostic services	100%	\$0	\$0

PARTS A L R	ALR	ARTS	P
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1 2		PARTS A & B		
3		<del></del>		
4	HOME HEALTH CARE			
5	Medicare Approved			
6	Services			
7	Medically necessary			
8	skilled care services			
9	and medical supplies	100%	\$0	\$0
10	Durable medical equip-			
11	ment			
12	First \$100 of Medicare			
13	Approved Amounts*	\$0	\$0	\$100 (Part B
14				Deductible)
15	Remainder of Medicare			
16	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
26	Benefit for each visit	\$0	Actual Charges	
27	<u>.</u>		to \$40 a visit	
28	Number of visits cov-	\$0	Up to the num-	
29	ered (must be received		ber of Medicare	
30	within 8 weeks of last		Approved	
31	Medicare Approved		visits not to	
32	visit)		exceed 7 each	
33	<b>G-13</b>	00	week	
34	Calendar year maxımum	\$0	\$1 600	
35				

## OTHER BENEFITS -- NOT COVERED BY MEDICARE

1 2	OTHER BENE	FITSNOT COVERE	D BY MEDICARE	
7 8 9	FOREIGN TRAVEL Not covered by Medicare Medically necessary emer- gency care services begin- ning during the first 60 days of each trip outside the USA			
11	First \$250 each calen-	\$0	\$0	\$250
13 14 15 16 17 18	dar year Remainder of Charges*	\$0	80% to a life- time maximum benefit of \$50 000	20% and amounts over the \$50 000 lifetime maximum
21	BASIC OUTPATIENT PRE- SCRIPTION DRUGS			
23	Not covered by Medicare First \$250 each calendar year	\$0	\$0	\$250
25	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

1 PLAN J

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

3 \*A benefit period begins on the first day you receive service as an inpa-4 tient in a hospital and ends after you have been out of the hospital and 5 have not received skilled care in any other facility for 60 days in a 6 row

7				
8 9 10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
13 14 15	HOSPITALIZATION* Semiprivate room and board general nursing and mis- cellaneous services and supplies			
17 18 19	First 60 days	All but \$628	\$628 (Part A Deductible)	\$0
20 21 22	61st thru 90th day 91st day and afterWhile using 60 lifetime	All but \$157 a day	\$157 a day	\$0
23 24 25	reserve daysOnce lifetime reserve days are used	All but \$314 a day	\$314 a day	\$0
26 27 28 29	Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
30 31 32	Beyond the Additional 365 days	\$0	\$0	All Costs
33 34 35 36 37 38 39 40 41	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  21st thru 100th day	All approved amounts All but \$78 50 a day	\$0 Up to \$78 50 a day \$0	\$0 \$0 All costs
40	forst day and after	150	130	MII COSCS

4	BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
9 10 11 12	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

1 PLAN J

2

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

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

6				
7 8 9	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
10 11 12 13 14 15 16 17 18 19 20 21 22 22 22 22 23 33 33 33 33 33 33 33 33	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*  Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 80% (GENERALLY) \$0	\$100 (Part B Deductible) 20% (GENERALLY)	\$0 \$0 \$0
	BLOOD First 3 pints Next \$100 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$100 (Part B Deductible) 20%	\$0 \$0 \$0
41	CLINICAL LABORATORY SERVICES Blood tests for diagnostic services	100%	\$0	\$0

## PARTS A & B

1 2	PARTS A & B			
3 4 5 6 7 8	HOME HEALTH CARE Medicare Approved ServicesMedically necessary skilled care services			
9 10 11	<pre>and medical suppliesDurable medical equip- ment</pre>	100%	\$0	\$0
12 13 14	First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
18 19 20 21 22 23 24 25	Remainder of Medicare Approved Amounts 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 Treat- ment Plan	80%	20%	\$0
27 28	Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
29 30 31 32 33 34	Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the num- ber of Medicare Approved visits not to exceed 7 each week	
35 36	Calendar year maxımum	\$0	\$1 600	

## OTHER BENEFITS--NOT COVERED BY MEDICARE

1 2	OTHER BENEFITSNOT COVERED BY MEDICARE			
3 4 5 6 7 8	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
12 13 14 15 16 17 18 19	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	\$0	\$0	\$250
23 24 25 26 27	year Next \$6,000 each calendar year	\$0	50%\$3 000 calendar year maxımum benefit	50%
28 29 30	Over \$6,000 each calendar year	\$0	\$0	All Costs
33 34 35 36 37 38 39 40 41 42 43 44 45 46 47	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	<b>c</b> 0	¢1.20	<b>S</b> O
49 50 51 52	First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All costs

- 1 Sec 3823 An insurance policy shall not be titled
- 2 advertised solicited or issued for delivery in this state as a
- 3 medicare supplement policy unless the definitions and terms con-
- 4 tained in the policy are such that covered benefits under the
- 5 policy are not more restrictive than covered benefits under medi-
- 6 care and those required to be provided under state law A MEDI-
- 7 CARE SUPPLEMENT POLICY SHALL CONTAIN A DEFINITION OF MEDICARE AS
- 8 THAT TERM IS DEFINED IN SECTION 3801 OR SUBSTANTIALLY SIMILAR TO
- 9 THAT DEFINITION
- 10 Sec 3839 (1) Each medicare supplement policy shall include
- II a renewal or continuation provision. The provision shall be
- 12 appropriately captioned, shall appear on the first page of the
- 13 policy, and shall clearly state the term of coverage for which
- 14 the policy is issued and for which it may be renewed. The provi-
- 15 sion shall include any reservation by the insurer of the right to
- 16 change premiums and any automatic renewal premium increases based
- 17 on the policyholder's age
- 18 (2) If a medicare supplement policy is terminated by the
- 19 group policyholder and is not replaced as provided under
- 20 subsection (4), the issuer shall offer certificate holders an
- 21 individual medicare supplement policy that at the option of the
- 22 certificate holder provides for contiluation of the benefits con-
- 23 tained in the group policy or provides for such benefits as oth-
- 24 erwise meet the requirements of section 3819
- 25 (3) If an individual is a certificate holder in a group
- 26 medicare supplement policy and the individual terminates
- 27 membership in the group the issuer shall offer the certificate

- 1 holder the conversion opportunity described in subsection -(4)-
- 2 (2) or at the option of the group policyholder offer the certif-
- 3 icate holder continuation of coverage under the group policy
- 4 (4) If a group medicare supplement policy is replaced by
- 5 another group medicare supplement policy purchased by the same
- 6 policyholder, the succeeding issuer shall offer coverage to all
- 7 persons covered under the old group policy on its date of
- 8 termination Coverage under the new policy shall not result in
- 9 any exclusion for preexisting conditions that would have been
- 10 covered under the group policy being replaced
- 11 Sec 3857 (1) An insurer shall do all of the following
- 12 (a) Accept a notice from a medicare carrier on dually
- 13 assigned claims submitted by participating physicians and suppli-
- 14 ers as a claim for benefits in place of any other claim form oth-
- 15 erwise required and make a payment determination on the basis of
- 16 the information contained in that notice
- (b) Notify the participating physician or supplier and the
- 18 beneficiary of the payment determination
- (c) Pay the participating physician or supplier directly
- (d) Furnish at the time of enrollment each enrollee with a
- 21 card listing the policy name, number, and a central mailing
- 22 address to which notices from a medicare carrier may be sent
- (e) Pay user fees for claim notices that are transmitted
- 24 electronically or otherwise
- 25 (f) Provide to the secretary of health and human services
- 26 at least annually, a central mailing address to which all claims
- 27 may be sent by medicare carriers

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- (2) Compliance with the requirements set forth in
- 2 subsection -(+)(a) (1) shall be certified on the medicare sup-
- 3 plement insurance experience reporting form

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