SUBSTITUTE FOR

HOUSE BILL NO. 6359

[A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending sections 3801, 3805, 3807, 3809, 3811, 3815, 3817, 3819, 3823, 3827, 3830, 3831, 3835, 3839, 3841, and 3849 (MCL 500.3801, 500.3805, 500.3807, 500.3809, 500.3811, 500.3815, 500.3817, 500.3819, 500.3823, 500.3827, 500.3830, 500.3831, 500.3835, 500.3839, 500.3841, and 500.3849), sections 3801, 3807, 3809, 3811, 3815, and 3819 as amended and section 3830 as added by 2002 PA 304 and sections 3805, 3817, 3823, 3827, 3831, 3835, 3839, 3841, and 3849 as added by 1992 PA 84, and by adding section 3804; and to repeal acts and parts of acts.]

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 3801. As used in this chapter:

(a) "Applicant" means:

(*i*) For an individual medicare supplement policy, the person

who seeks to contract for ~~insurance~~ benefits.

(*ii*) For a group medicare supplement policy **OR CERTIFICATE**, the proposed certificate holder.

(b) "Bankruptcy" means when a ~~medicare+choice~~ **MEDICARE ADVANTAGE** organization that is not an insurer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in this state.

(c) "Certificate" means any certificate delivered or issued for delivery in this state under a group medicare supplement policy.

(d) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the insurer.

(e) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

(f) "Creditable coverage" means coverage of an individual provided under any of the following:

(*i*) A group health plan.

(*ii*) Health insurance coverage.

(*iii*) Part A or part B of medicare.

(*iv*) Medicaid other than coverage consisting solely of benefits under section 1928 of medicaid, 42 ~~U.S.C.~~ **USC** 1396s.

(*v*) Chapter 55 of title 10 of the United States Code, 10 ~~U.S.C.~~ **USC** 1071 to 1110.

(*vi*) A medical care program of the Indian health service or of a tribal organization.

(*vii*) A state health benefits risk pool.

(*viii*) A health plan offered under chapter 89 of title 5 of the United States Code, 5 ~~U.S.C.~~ **USC** 8901 to 8914.

(*ix*) A public health plan as defined in federal regulation.

(*x*) Health care under section 5(e) of title I of the peace corps act, ~~Public Law 87-293,~~ 22 ~~U.S.C.~~ **USC** 2504.

(g) "Direct response solicitation" means solicitation in which an insurer representative does not contact the applicant in person and explain the coverage available, such as, but not limited to, solicitation through direct mail or through advertisements in periodicals and other media.

(h) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in section 3 of subtitle A of title I of the employee retirement income security act of 1974, ~~Public Law 93-406,~~ 29 ~~U.S.C.~~ **USC** 1002.

(i) "Insolvency" means when an insurer licensed to transact the business of insurance in this state has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the insurer's state of domicile.

(j) "Insurer" includes any entity, including a health care corporation **OPERATING PURSUANT TO THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT, 1980 PA 350, MCL 550.1101 TO 550.1704**, delivering or issuing for delivery in this state medicare supplement policies.

(k) "Medicaid" means title XIX of the social security act, ~~chapter 531, 49 Stat. 620,~~ 42 ~~U.S.C.~~ **USC** 1396 to ~~1396r-6 and~~

~~1396r-8 to~~ 1396v.

(*l*) "Medicare" means title XVIII of the social security act, ~~chapter 531, 49 Stat. 620,~~ 42 ~~U.S.C.~~ **USC** 1395 to ~~1395b, 1395b-2, 1395b-6 to 1395b-7, 1395c to 1395i, 1395i-2 to 1395i-5, 1395j to 1395t, 1395u to 1395w, 1395w-2 to 1395w-4, 1395w-21 to 1395w-28, 1395x to 1395yy, and 1395bbb to~~ 1395ggg.

(m) ~~"Medicare choice plan"~~ **"MEDICARE ADVANTAGE"** means a plan of coverage for health benefits under medicare part C as defined in section 12-2859 of part C of medicare, 42 ~~U.S.C.~~ **USC** 1395w-28, and includes any of the following:

(*i*) Coordinated care plans that provide health care services, including, but not limited to, health maintenance organization plans with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans.

(*ii*) Medical savings account plans coupled with a contribution into a ~~medicare choice~~ **MEDICARE ADVANTAGE** medical savings account.

(*iii*) ~~Medicare choice~~ **MEDICARE ADVANTAGE** private fee-for-service plans.

(n) "Medicare supplement buyer's guide" means the document entitled, "guide to health insurance for people with medicare", developed by the national association of insurance commissioners and the United States department of health and human services or a substantially similar document as approved by the commissioner.

(o) "Medicare supplement policy" means an individual**,** **NONGROUP,** or group policy or certificate ~~of insurance~~ that is

advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare and medicare select policies and certificates under section 3817. Medicare supplement policy does not include a policy**, CERTIFICATE,** or contract of 1 or more employers or labor organizations, or of the trustees of a fund established by 1 or more employers or labor organizations, or both, for employees or former employees, or both, or for members or former members, or both, of the labor organizations. **MEDICARE SUPPLEMENT POLICY DOES NOT INCLUDE MEDICARE ADVANTAGE PLANS ESTABLISHED UNDER MEDICARE PART C, OUTPATIENT PRESCRIPTION DRUG PLANS ESTABLISHED UNDER MEDICARE PART D, OR ANY HEALTH CARE PREPAYMENT PLAN THAT PROVIDES BENEFITS PURSUANT TO AN AGREEMENT UNDER SECTION 1833(A)(1)(A) OF THE SOCIAL SECURITY ACT.**

(p) "PACE" means a program of all-inclusive care for the elderly as described in the social security act.

(q) "Policy form" means the form on which the policy **OR CERTIFICATE** is delivered or issued for delivery by the insurer.

(r) "Secretary" means the secretary of the United States department of health and human services.

(s) "Social security act" means the social security act, ~~chapter 531, 49 Stat. 620~~ **42 USC 301 TO 1397JJ**.

SEC. 3804. THIS CHAPTER APPLIES TO A MEDICARE SUPPLEMENT POLICY DELIVERED, ISSUED FOR DELIVERY, OR RENEWED BY A HEALTH CARE CORPORATION OPERATING PURSUANT TO THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT, 1980 PA 350, MCL 550.1101 TO 550.1704, ON

OR AFTER THE EFFECTIVE DATE OF THIS SECTION.

Sec. 3805. As used in a medicare supplement policy:

(a) The definition of "accident", "accidental injury", or "accidental means" shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any worker's compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

(b) The definition of "benefit period" or "medicare benefit period" shall not be defined in a more restrictive manner than as defined in medicare.

(c) "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the joint commission on accreditation of hospitals, but not more restrictively than as defined in medicare.

(d) The definition of "medicare eligible expenses" shall mean health care expenses of the kinds covered by **PART A AND PART B OF** medicare, to the extent recognized as reasonable and medically necessary by medicare.

(e) "Nurses" may be defined so that the description of nurse is to a type of nurse, such as a registered professional nurse or a licensed practical nurse. If the words "nurse", "trained nurse", or "registered nurse" are used without specific instruction, then the use of those terms requires the insurer to

recognize the services of any individual who qualifies under those terms in accordance with the public health code, ~~Act No. 368 of the Public Acts of 1978, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws~~ **1978 PA 368, MCL 333.1101 TO 333.25211**.

(f) "Physician" shall not be defined more restrictively than as defined in medicare.

(g) "Sickness" shall not be defined more restrictively than to mean illness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. The definition may be further modified to exclude sicknesses or diseases for which benefits are provided to the insured under any worker's compensation, occupational disease, employer's liability, or similar law.

(h) "Skilled nursing facility" shall not be defined more restrictively than as defined in medicare.

Sec. 3807. **(1)** Every insurer issuing a medicare supplement insurance policy in this state shall make available a medicare supplement insurance policy that includes 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 **100% OF** the medicare part A eligible expenses for hospitalization paid at the ~~diagnostic related group day outlier per diem~~ **APPLICABLE PROSPECTIVE PAYMENT SYSTEM RATE** or other appropriate **MEDICARE** 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, or the copayment amount paid for hospital outpatient department services under a prospective payment system, of medicare eligible expenses under part B regardless of hospital confinement, subject to the medicare part B deductible.

(2) STANDARDS FOR PLANS K AND L ARE AS FOLLOWS:

(A) STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN K SHALL CONSIST OF THE FOLLOWING:

(*i*) COVERAGE OF 100% OF THE PART A HOSPITAL COINSURANCE AMOUNT FOR EACH DAY USED FROM THE SIXTY-FIRST DAY THROUGH THE NINETIETH DAY IN ANY MEDICARE BENEFIT PERIOD.

(*ii*) COVERAGE OF 100% OF THE PART A HOSPITAL COINSURANCE

AMOUNT FOR EACH MEDICARE LIFETIME INPATIENT RESERVE DAY USED FROM THE NINETY-FIRST DAY THROUGH THE ONE HUNDRED FIFTIETH DAY IN ANY MEDICARE BENEFIT PERIOD.

(*iii*) UPON EXHAUSTION OF THE MEDICARE HOSPITAL INPATIENT COVERAGE, INCLUDING THE LIFETIME RESERVE DAYS, COVERAGE OF 100% OF THE MEDICARE PART A ELIGIBLE EXPENSES FOR HOSPITALIZATION PAID AT THE APPLICABLE PROSPECTIVE PAYMENT SYSTEM RATE, OR OTHER APPROPRIATE MEDICARE STANDARD OF PAYMENT, SUBJECT TO A LIFETIME MAXIMUM BENEFIT OF AN ADDITIONAL 365 DAYS. THE PROVIDER SHALL ACCEPT THE INSURER'S PAYMENT AS PAYMENT IN FULL AND MAY NOT BILL THE INSURED FOR ANY BALANCE.

(*iv*) MEDICARE PART A DEDUCTIBLE: COVERAGE FOR 50% OF THE MEDICARE PART A INPATIENT HOSPITAL DEDUCTIBLE AMOUNT PER BENEFIT PERIOD UNTIL THE OUT-OF-POCKET LIMITATION IS MET AS DESCRIBED IN SUBPARAGRAPH (*x*).

(*v*) SKILLED NURSING FACILITY CARE: COVERAGE FOR 50% OF THE COINSURANCE AMOUNT FOR EACH DAY USED FROM THE TWENTY-FIRST DAY THROUGH THE ONE HUNDREDTH DAY IN A MEDICARE BENEFIT PERIOD FOR POSTHOSPITAL SKILLED NURSING FACILITY CARE ELIGIBLE UNDER MEDICARE PART A UNTIL THE OUT-OF-POCKET LIMITATION IS MET AS DESCRIBED IN SUBPARAGRAPH (*x*).

(*vi*) HOSPICE CARE: COVERAGE FOR 50% OF COST SHARING FOR ALL PART A MEDICARE ELIGIBLE EXPENSES AND RESPITE CARE UNTIL THE OUT-OF-POCKET LIMITATION IS MET AS DESCRIBED IN SUBPARAGRAPH (*x*).

(*vii*) COVERAGE FOR 50%, UNDER MEDICARE PART A OR B, OF 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 UNTIL THE OUT-OF-POCKET LIMITATION IS MET AS DESCRIBED IN SUBPARAGRAPH (*x*).

(*viii*) EXCEPT FOR COVERAGE PROVIDED IN SUBPARAGRAPH (*ix*) BELOW, COVERAGE FOR 50% OF THE COST SHARING OTHERWISE APPLICABLE UNDER MEDICARE PART B AFTER THE POLICYHOLDER PAYS THE PART B DEDUCTIBLE UNTIL THE OUT-OF-POCKET LIMITATION IS MET AS DESCRIBED IN SUBPARAGRAPH (*x*).

(*ix*) COVERAGE OF 100% OF THE COST SHARING FOR MEDICARE PART B PREVENTIVE SERVICES AFTER THE POLICYHOLDER PAYS THE PART B DEDUCTIBLE.

(*x*) COVERAGE OF 100% OF ALL COST SHARING UNDER MEDICARE PARTS A AND B FOR THE BALANCE OF THE CALENDAR YEAR AFTER THE INDIVIDUAL HAS REACHED THE OUT-OF-POCKET LIMITATION ON ANNUAL EXPENDITURES UNDER MEDICARE PARTS A AND B OF $4,000.00 IN 2006, INDEXED EACH YEAR BY THE APPROPRIATE INFLATION ADJUSTMENT SPECIFIED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(B) STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN L SHALL CONSIST OF THE FOLLOWING:

(*i*) THE BENEFITS DESCRIBED IN SUBDIVISION (A)(*i*), (*ii*), (*iii*), AND (*ix*).

(*ii*) THE BENEFIT DESCRIBED IN SUBDIVISION (A)(*iv*), (*v*), (*vi*), (*vii*), AND (*viii*), BUT SUBSTITUTING 75% FOR 50%.

(*iii*) THE BENEFIT DESCRIBED IN SUBDIVISION (A)(*x*), BUT SUBSTITUTING $2,000.00 FOR $4,000.00.

Sec. 3809. (1) In addition to the basic core package of

benefits required under section 3807, the following benefits may be included in a medicare supplement insurance policy and if included shall conform to section 3811(5)(b) to (j):

(a) Medicare part A deductible: coverage for all of the medicare part A inpatient hospital deductible amount per benefit period.

(b) Skilled nursing facility care: coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare part A.

(c) Medicare part B deductible: coverage for all of the medicare part B deductible amount per calendar year regardless of hospital confinement.

(d) Eighty percent of the medicare part B excess charges: coverage for 80% of the difference between the actual medicare part B charge as billed, not to exceed any charge limitation established by medicare or state law, and the medicare-approved part B charge.

(e) One hundred percent of the medicare part B excess charges: coverage for all of the difference between the actual medicare part B charge as billed, not to exceed any charge limitation established by medicare or state law, and the medicare-approved part B charge.

(f) Basic outpatient prescription drug benefit: coverage for 50% of outpatient prescription drug charges, after a $250.00 calendar year deductible, to a maximum of $1,250.00 in benefits

received by the insured per calendar year, to the extent not covered by medicare. **THE OUTPATIENT PRESCRIPTION DRUG BENEFIT MAY BE INCLUDED FOR SALE OR ISSUANCE IN A MEDICARE SUPPLEMENT POLICY UNTIL JANUARY 1, 2006.**

(g) Extended outpatient prescription drug benefit: coverage for 50% of outpatient prescription drug charges, after a $250.00 calendar year deductible, to a maximum of $3,000.00 in benefits received by the insured per calendar year, to the extent not covered by medicare. **THE OUTPATIENT PRESCRIPTION DRUG BENEFIT MAY BE INCLUDED FOR SALE OR ISSUANCE IN A MEDICARE SUPPLEMENT POLICY UNTIL JANUARY 1, 2006.**

(h) Medically necessary emergency care in a foreign country: coverage to the extent not covered by medicare for 80% of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250.00, and a lifetime maximum benefit of $50,000.00. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(i) Preventive medical care benefit: Coverage for the following preventive health services **NOT COVERED BY MEDICARE**:

(*i*) An annual clinical preventive medical history and physical examination that may include tests and services from

subparagraph (*ii*) and patient education to address preventive health care measures.

(*ii*) ~~Any 1 or a combination of the following preventive~~ **PREVENTIVE** screening tests or preventive services, the **SELECTION AND** frequency of which is ~~considered~~ **DETERMINED TO BE** medically appropriate ~~:~~ **BY THE ATTENDING PHYSICIAN.**

~~(A) Digital rectal examination.~~

~~(B) Dipstick urinalysis for hematuria, bacteriuria, and proteinuria.~~

~~(C) Pure tone, air only, hearing screening test, administered or ordered by a physician.~~

~~(D) Serum cholesterol screening every 5 years.~~

~~(E) Thyroid function test.~~

~~(F) Diabetes screening.~~

~~(G) Tetanus and diphtheria booster every 10 years.~~

~~(H) Any other tests or preventive measures determined appropriate by the attending physician.~~

(j) At-home recovery benefit: coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery. At-home recovery services provided shall be primarily services that assist in activities of daily living. The insured's attending physician shall certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by medicare. Coverage is excluded for home care visits paid for by medicare or other government programs and care provided by family

members, unpaid volunteers, or providers who are not care providers. Coverage is limited to:

(*i*) No more than the number of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of medicare approved home health care visits under a medicare approved home care plan of treatment.

(*ii*) The actual charges for each visit up to a maximum reimbursement of $40.00 per visit.

(*iii*) One thousand six hundred dollars per calendar year.

(*iv*) Seven visits in any 1 week.

(*v*) Care furnished on a visiting basis in the insured's home.

(*vi*) Services provided by a care provider as defined in this section.

(*vii*) At-home recovery visits while the insured is covered under the insurance policy and not otherwise excluded.

(*viii*) At-home recovery visits received during the period the insured is receiving medicare approved home care services or no more than 8 weeks after the service date of the last medicare approved home health care visit.

(k) New or innovative benefits: an insurer may, with the prior approval of the commissioner, offer **POLICIES OR CERTIFICATES WITH** new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. ~~These~~ **THE NEW OR INNOVATIVE** benefits may include benefits that are appropriate to

medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of medicare supplement policies. **AFTER DECEMBER 31, 2005, THE INNOVATIVE BENEFIT SHALL NOT INCLUDE AN OUTPATIENT PRESCRIPTION DRUG BENEFIT.**

(2) Reimbursement for the preventive screening tests and services under subsection (1)(i)(*ii*) shall be for the actual charges up to 100% of the medicare-approved amount for each test or service, as if medicare were to cover the test or service as identified in the American medical association current procedural terminology codes, to a maximum of $120.00 annually under this benefit. This benefit shall not include payment for any procedure covered by medicare.

(3) As used in subsection (1)(j):

(a) "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(b) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(c) "Home" means any place used by the insured as a place of residence, provided that it qualifies as a residence for home health care services covered by medicare. A hospital or skilled nursing facility shall not be considered the insured's home.

(d) "At-home recovery visit" means the period of a visit

required to provide at home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is 1 visit.

Sec. 3811. (1) An insurer shall make available to each prospective medicare supplement policyholder and certificate holder a policy form or certificate form containing only the basic core benefits as provided in section 3807.

(2) Groups, packages, or combinations of medicare supplement benefits other than those listed in this section shall not be offered for sale in this state except as may be permitted in section 3809(1)(k).

(3) Benefit plans shall contain the appropriate A through ~~J~~ **L** designations, shall be uniform in structure, language, and format to the standard benefit plans in subsection (5), and shall conform to the definitions in this chapter. Each benefit shall be structured in accordance with sections 3807 and 3809 and list the benefits in the order shown in subsection (5). For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

(4) In addition to the benefit plan designations A through ~~J~~ **L** as provided under subsection (5), an insurer may use other designations to the extent permitted by law.

(5) A medicare supplement insurance benefit plan shall conform to 1 of the following:

(a) A standardized medicare supplement benefit plan A shall be limited to the basic core benefits common to all benefit plans as defined in section 3807.

(b) A standardized medicare supplement benefit plan B shall include only the following: the core benefits as defined in section 3807 and the medicare part A deductible as defined in section 3809(1)(a).

(c) A standardized medicare supplement benefit plan C shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (c), and (h).

(d) A standardized medicare supplement benefit plan D shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in section 3809(1)(a), (b), (h), and (j).

(e) A standardized medicare supplement benefit plan E shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in section 3809(1)(a), (b), (h), and (i).

(f) A standardized medicare supplement benefit plan F shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, and medically necessary emergency care in

a foreign country as defined in section 3809(1)(a), (b), (c), (e), and (h). A standardized medicare supplement plan F high deductible shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan F deductible. The covered expenses include the core benefits as defined in section 3807, plus the medicare part A deductible, skilled nursing facility care, the medicare part B deductible, 100% of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (c), (e), and (h). The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan F policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan F deductible is ~~$1,580.00~~ **$1,790.00** for calendar year ~~2001~~ **2006**, and the secretary shall adjust it annually thereafter to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10.00.

(g) A standardized medicare supplement benefit plan G shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, 80% of the medicare part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in section 3809(1)(a), (b), (d), (h), and (j).

(h) A standardized medicare supplement benefit plan H shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (f), and (h). **THE OUTPATIENT DRUG BENEFIT SHALL NOT BE INCLUDED IN A MEDICARE SUPPLEMENT POLICY SOLD AFTER DECEMBER 31, 2005.**

(i) A standardized medicare supplement benefit plan I shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, 100% of the medicare part B excess charges, basic outpatient prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in section 3809(1)(a), (b), (e), (f), (h), and (j). **THE OUTPATIENT DRUG BENEFIT SHALL NOT BE INCLUDED IN A MEDICARE SUPPLEMENT POLICY SOLD AFTER DECEMBER 31, 2005.**

(j) A standardized medicare supplement benefit plan J shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in section 3809(1)(a), (b), (c), (e), (g), (h), (i), and (j). A standardized medicare supplement benefit plan J high deductible plan shall consist of only the following: 100% of covered

expenses following the payment of the annual high deductible plan J deductible. The covered expenses include the core benefits as defined in section 3807, plus the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in section 3809(1)(a), (b), (c), (e), (g), (h), (i), and (j). The annual high deductible plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be ~~$1,580.00~~ **$1,790.00** for calendar year ~~2001~~ **2006**, and the secretary shall adjust it annually thereafter to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10.00. **THE OUTPATIENT DRUG BENEFIT SHALL NOT BE INCLUDED IN A MEDICARE SUPPLEMENT POLICY SOLD AFTER DECEMBER 31, 2005.**

(K) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN K SHALL CONSIST OF ONLY THOSE BENEFITS DESCRIBED IN SECTION 3807(2)(A).

(*l*) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN L SHALL CONSIST OF ONLY THOSE BENEFITS DESCRIBED IN SECTION 3807(2)(B).

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) INSURERS SHALL COMPLY WITH ANY NOTICE REQUIREMENTS OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003, PUBLIC LAW 108-173.

(3) ~~(2)~~ If an outline of coverage is provided at the time of application and the medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate 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.

(4) ~~(3)~~ An outline of coverage under subsection (1) shall be in the language and format prescribed in this section and in not less than 12-point type. The A through ~~J~~ **L** 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~~ **12** standard plans plus 2 high deductible 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.~~ **FOR PLANS A-J.**

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

Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses) or ~~, for hospital outpatient department services under a prospective payment system, applicable~~ copayments **FOR HOSPITAL OUTPATIENT SERVICES**.

Blood: First three pints of blood each year.

		A	B	C	D	E	F|**F***	G	H	I	J|**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 **NOT COVERED BY MEDICARE**						X					X

[COMPANY NAME]

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE - COVER PAGE 2

BASIC BENEFITS FOR PLANS K AND L INCLUDE SIMILAR SERVICES AS PLANS A-J, BUT COST-SHARING FOR THE BASIC BENEFITS IS AT DIFFERENT LEVELS.

		K**	L**
	BASIC BENEFITS	100% OF PART A HOSPITALIZATION COINSURANCE PLUS COVERAGE FOR 365 DAYS AFTER MEDICARE BENEFITS END 50% HOSPICE COST-SHARING 50% OF MEDICARE-ELIGIBLE EXPENSES FOR THE FIRST THREE PINTS OF BLOOD 50% PART B COINSURANCE, EXCEPT 100% COINSURANCE FOR PART B PREVENTIVE SERVICES	100% OF PART A HOSPITALIZATION COINSURANCE PLUS COVERAGE FOR 365 DAYS AFTER MEDICARE BENEFITS END 75% HOSPICE COST-SHARING 75% OF MEDICARE-ELIGIBLE EXPENSES FOR THE FIRST THREE PINTS OF BLOOD 75% PART B COINSURANCE, EXCEPT 100% COINSURANCE FOR PART B PREVENTIVE SERVICES
	SKILLED NURSING COINSURANCE	50% SKILLED NURSING FACILITY COINSURANCE	75% SKILLED NURSING FACILITY COINSURANCE
	PART A DEDUCTIBLE	50% PART A DEDUCTIBLE	75% PART A DEDUCTIBLE
	PART B DEDUCTIBLE		
	PART B EXCESS (100%)		
	FOREIGN TRAVEL EMERGENCY		
	AT-HOME RECOVERY		
	PREVENTIVE CARE NOT		

1		COVERED BY MEDICARE		
2			$4,000 OUT OF POCKET	$2,000 OUT OF POCKET
3			ANNUAL LIMIT***	ANNUAL LIMIT***

***PLANS F AND J ALSO HAVE AN OPTION CALLED A HIGH DEDUCTIBLE PLAN F AND A HIGH DEDUCTIBLE PLAN J. THESE HIGH DEDUCTIBLE PLANS PAY THE SAME BENEFITS AS PLANS F AND J AFTER ONE HAS PAID A CALENDAR YEAR ($1,790) DEDUCTIBLE. BENEFITS FROM HIGH DEDUCTIBLE PLANS F AND J WILL NOT BEGIN UNTIL OUT-OF-POCKET EXPENSES EXCEED ($1,790). OUT-OF-POCKET EXPENSES FOR THIS DEDUCTIBLE ARE EXPENSES THAT WOULD ORDINARILY BE PAID BY THE POLICY. THESE EXPENSES INCLUDE THE MEDICARE DEDUCTIBLES FOR PART A AND PART B, BUT DO NOT INCLUDE THE PLAN'S SEPARATE FOREIGN TRAVEL EMERGENCY DEDUCTIBLE.**

**** PLANS K AND L PROVIDE FOR DIFFERENT COST-SHARING FOR ITEMS AND SERVICES THAN PLANS A-J.**

ONCE YOU REACH THE ANNUAL LIMIT, THE PLAN PAYS 100% OF THE MEDICARE COPAYMENTS, COINSURANCE, AND DEDUCTIBLES FOR THE REST OF THE CALENDAR YEAR. THE OUT-OF-POCKET ANNUAL LIMIT DOES NOT INCLUDE CHARGES FROM YOUR PROVIDER THAT EXCEED MEDICARE-APPROVED AMOUNTS, CALL "EXCESS CHARGES". YOU WILL BE RESPONSIBLE FOR PAYING EXCESS CHARGES.

***** THE OUT-OF-POCKET ANNUAL LIMIT WILL INCREASE EACH YEAR FOR INFLATION.**

SEE OUTLINES OF COVERAGE FOR DETAILS AND EXCEPTIONS.

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). 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 ~~$792~~ **$952**	$0	~~$792~~ **$952** (Part A Deductible)
61st thru 90th day	All but ~~$198~~ **$238** a day	~~$198~~ **$238** a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~$396~~ **$476** a day	~~$396~~ **$476** 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 ~~$99~~ **$119** a day	$0	Up to ~~$99~~ **$119** 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	All but very limited coinsurance for outpatient	$0	Balance

services	drugs and inpatient respite care		

PLAN A

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

*Once you have been billed ~~$100~~ **$124** 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~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges			

(Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next ~~$100~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			
~~Blood tests~~ **TESTS** for diagnostic services	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 equipment			
First ~~$100~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (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 ~~$792~~ **$952**	~~$792~~ **$952** (Part A Deductible)	$0
61st thru 90th day	All but ~~$198~~ **$238** a day	~~$198~~ **$238** a day	$0
91st day and after —While using 60 lifetime reserve days	All but ~~$396~~ **$476** a day	~~$396~~ **$476** a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible	$0

		Expenses	
—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 ~~$99~~ **$119** a day	$0	Up to ~~$99~~ **$119** 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~~ **$124** 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~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0

Next ~~$100~~ **$124** of Medicare			
Approved Amounts*	$0	$0	~~$100~~ **$124** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— ~~Blood tests~~ **TESTS** for diagnostic services	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 equipment First ~~$100~~ **$124** of Medicare			
Approved Amounts*	$0	$0	~~$100~~ **$124** (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 ~~$792~~ **$952**	~~$792~~ **$952** (Part A Deductible)	$0
61st thru 90th day	All but ~~$198~~ **$238** a day	~~$198~~ **$238** a day	$0
91st day and after —While using 60 lifetime reserve days	All but ~~$396~~ **$476** a day	~~$396~~ **$476** 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 ~~$99~~ **$119** a day	Up to ~~$99~~ **$119** 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~~ **$124** 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~~ **$124** of Medicare Approved Amounts*	$0	~~$100~~ **$124** (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next ~~$100~~ **$124** of Medicare Approved Amounts*	$0	~~$100~~ **$124** (Part B	$0

		Deductible)	
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— ~~Blood tests~~ **TESTS** for diagnostic services	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 equipment First ~~$100~~ **$124** of Medicare Approved Amounts*	$0	~~$100~~ **$124** (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 ~~$792~~ **$952**	~~$792~~ **$952** (Part A Deductible)	$0
61st thru 90th day	All but ~~$198~~ **$238**	~~$198~~ **$238**	$0

	a day	a day	
91st day and after			
—While using 60			
lifetime reserve days	All but ~~$396~~ **$476** a day	~~$396~~ **$476** 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 ~~$99~~ **$119** a day	Up to ~~$99~~ **$119** 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~~ **$124** 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~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next ~~$100~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— ~~Blood tests~~ **TESTS** for diagnostic services	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			

equipment			
First ~~$100~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (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	

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	20% and
		lifetime	amounts
		maximum	over the
		benefit	$50,000
		of $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 ~~$792~~ **$952**	~~$792~~ **$952** (Part A Deductible)	$0
61st thru 90th day	All but ~~$198~~ **$238** a day	~~$198~~ **$238** a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but ~~$396~~ **$476** a day	~~$396~~ **$476** 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 ~~$99~~ **$119** a day	Up to ~~$99~~ **$119** 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~~ **$124** 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~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next ~~$100~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— ~~Blood tests~~ **TESTS** for diagnostic services	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 equipment First ~~$100~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (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	20% and amounts over the

		benefit of $50,000	$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 OR HIGH DEDUCTIBLE 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.

This high deductible plan pays the same ~~or offers the same~~ benefits as plan F after you have paid a calendar year ~~($1,580)~~ **($1,790) deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are ~~$1,580~~ **$1,790**. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes medicare deductibles for part A and part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1,580~~ **$1,790** DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO ~~$1,580~~ **$1,790** DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$792~~ **$952**	~~$792~~ **$952** (Part A Deductible)	$0
61st thru 90th day	All but ~~$198~~ **$238** a day	~~$198~~ **$238** a day	$0
91st day and after —While using 60			

lifetime reserve days	All but ~~$396~~ **$476** a day	~~$396~~ **$476** 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 ~~$99~~ **$119** a day	Up to ~~$99~~ **$119** 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~~ **$124** 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. **This high deductible plan pays the same ~~or offers the same~~ benefits as plan F after you have paid a calendar year ~~($1,580)~~ **($1,790)** deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are ~~$1,580~~ **$1,790**. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes medicare deductibles for part A and part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1,580~~ **$1,790** DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO ~~$1,580~~ **$1,790** DEDUCTIBLE**, 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~~ **$124** of Medicare Approved Amounts*	$0	~~$100~~ **$124** (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next ~~$100~~ **$124** of Medicare Approved Amounts*	$0	~~$100~~ **$124** (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			

~~Blood tests~~ **TESTS** for diagnostic services	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 equipment First ~~$100~~ **$124** of Medicare Approved Amounts*	$0	~~$100~~ **$124** (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	20% and

		lifetime maximum benefit of $50,000	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 ~~$792~~ **$952**	~~$792~~ **$952** (Part A Deductible)	$0
61st thru 90th day	All but ~~$198~~ **$238** a day	~~$198~~ **$238** a day	$0
91st day and after —While using 60 lifetime reserve days	All but ~~$396~~ **$476**	~~$396~~ **$476**	$0

	a day	a day	
—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 ~~$99~~ **$119** a day	Up to ~~$99~~ **$119** 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	All but very limited	$0	Balance

terminally ill and you elect to receive these services	coinsurance for outpatient drugs and inpatient respite care		

PLAN G

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

*Once you have been billed ~~$100~~ **$124** 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~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (Part B Deductible)

Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All Costs	$0
Next ~~$100~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— ~~Blood tests~~ **TESTS** for diagnostic services	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 equipment First ~~$100~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (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	

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 ~~$792~~ **$952**	~~$792~~ **$952** (Part A Deductible)	$0
61st thru 90th day	All but ~~$198~~ **$238** a day	~~$198~~ **$238** a day	$0
91st day and after —While using 60 lifetime reserve days	All but ~~$396~~ **$476** a day	~~$396~~ **$476** 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 ~~$99~~ **$119** a day	Up to ~~$99~~ **$119** 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~~ **$124** 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~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next ~~$100~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— ~~Blood tests~~ **TESTS** for diagnostic services	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 equipment			
First ~~$100~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (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 PRE-~~			

~~SCRIPTION 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 ~~$792~~ **$952**	~~$792~~ **$952** (Part A	$0

		Deductible)	
61st thru 90th day	All but ~~$198~~ **$238** a day	~~$198~~ **$238** a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but ~~$396~~ **$476** a day	~~$396~~ **$476** 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 ~~$99~~ **$119** a day	Up to ~~$99~~ **$119** 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~~ **$124** 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~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next ~~$100~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			
~~Blood tests~~ **TESTS** for diagnostic services	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 equipment			
First ~~$100~~ **$124** of Medicare Approved Amounts*	$0	$0	~~$100~~ **$124** (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	

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 OR HIGH DEDUCTIBLE 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.

This high deductible plan pays the same ~~or offers the same~~ benefits as plan J after you have paid a calendar year ~~($1,580)~~ **($1,790) deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are ~~$1,580~~ **$1,790**. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes medicare deductibles for part A and part B, but does not include the plan's **OUTPATIENT PRESCRIPTION DRUG DEDUCTIBLE OR** separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1,580~~ **$1,790** DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO ~~$1,580~~ **$1,790** DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing			

and miscellaneous services and supplies			
First 60 days	All but ~~$792~~ **$952**	~~$792~~ **$952** (Part A Deductible)	$0
61st thru 90th day	All but ~~$198~~ **$238** a day	~~$198~~ **$238** a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but ~~$396~~ **$476** a day	~~$396~~ **$476** 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 ~~$99~~ **$119** a day	Up to ~~$99~~ **$119** 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~~

*****NOTICE: WHEN YOUR MEDICARE PART A HOSPITAL BENEFITS ARE EXHAUSTED, THE INSURER STANDS IN THE PLACE OF MEDICARE AND WILL PAY WHATEVER AMOUNT MEDICARE WOULD HAVE PAID FOR UP TO AN ADDITIONAL 365 DAYS AS PROVIDED IN THE POLICY'S "CORE BENEFITS." DURING THIS TIME THE HOSPITAL IS PROHIBITED FROM BILLING YOU FOR THE BALANCE BASED ON ANY DIFFERENCE BETWEEN ITS BILLED CHARGES AND THE AMOUNT MEDICARE WOULD HAVE PAID.**

PLAN J

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

*Once you have been billed ~~$100~~ **$124** 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. **This high deductible plan pays the same or offers the same benefits as plan J after you have paid a calendar year ~~($1,580)~~ **($1,790)** deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are ~~$1,580~~ **$1,790**. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes medicare deductibles for part A and part B, but does not include the plan's separate **OUTPATIENT PRESCRIPTION DRUG DEDUCTIBLE OR** foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1,580~~ **$1,790** DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO ~~$1,580~~ **$1,790** DEDUCTIBLE**, YOU PAY
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**
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~~ **$124** of Medicare Approved Amounts*	$0	~~$100~~ **$124** (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next ~~$100~~ **$124** of Medicare Approved Amounts*	$0	~~$100~~ **$124** (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— **TESTS** for diagnostic services	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 equipment First ~~$100~~ **$124** of Medicare Approved Amounts*	$0	~~$100~~ **$124** (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 visit)			
Medicare Approved	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

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
~~EXTENDED OUTPATIENT PRESCRIPTION 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 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 K

*** YOU WILL PAY HALF THE COST-SHARING OF SOME COVERED SERVICES UNTIL YOU REACH THE ANNUAL OUT-OF-POCKET LIMIT OF $4,000 EACH CALENDAR YEAR. THE AMOUNTS THAT COUNT TOWARD YOUR ANNUAL LIMIT ARE NOTED WITH DIAMONDS (♦) IN THE CHART BELOW. ONCE YOU REACH THE ANNUAL LIMIT, THE PLAN PAYS 100% OF YOUR MEDICARE COPAYMENT AND COINSURANCE FOR THE REST OF THE CALENDAR YEAR. HOWEVER, THIS LIMIT DOES NOT INCLUDE CHARGES FROM YOUR PROVIDER THAT EXCEED MEDICARE-APPROVED AMOUNTS (THESE ARE CALLED "EXCESS CHARGES") AND YOU WILL BE RESPONSIBLE FOR PAYING THIS DIFFERENCE IN THE AMOUNT CHARGED BY YOUR PROVIDER AND THE AMOUNT PAID BY MEDICARE FOR THE ITEM OR SERVICE.**

PLAN K

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 $952	$476 (50% OF PART A DEDUCTI-BLE)	$476 (50% OF PART A DEDUCTIBLE)♦
61ST THRU 90TH DAY	ALL BUT $238 A DAY	$238 A DAY	$0
91ST DAY AND AFTER:			
—WHILE USING 60 LIFETIME RESERVE DAYS	ALL BUT $476 A DAY	$476 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	UP TO	UP TO
	$119 A	$59.50	$59.50
	DAY	A DAY	A DAY♦
101ST DAY AND AFTER	$0	$0	ALL COSTS
BLOOD			
FIRST 3 PINTS	$0	50%	50%♦
ADDITIONAL AMOUNTS	100%	$0	$0
HOSPICE CARE			
AVAILABLE AS LONG AS YOUR	GENERALLY,	50% OF	50% OF
DOCTOR CERTIFIES YOU ARE	MOST MEDICARE	COINSUR-	COINSUR-
TERMINALLY ILL AND YOU	ELIGIBLE	ANCE OR	ANCE OR
ELECT TO RECEIVE THESE	EXPENSES FOR	COPAYMENTS	COPAYMENTS♦
SERVICES	OUTPATIENT		
	DRUGS AND		
	INPATIENT		
	RESPITE CARE		

***NOTICE: WHEN YOUR MEDICARE PART A HOSPITAL BENEFITS ARE EXHAUSTED, THE INSURER STANDS IN THE PLACE OF MEDICARE AND WILL PAY WHATEVER AMOUNT MEDICARE WOULD HAVE PAID FOR UP TO AN ADDITIONAL 365 DAYS AS PROVIDED IN THE POLICY'S "CORE BENEFITS." DURING THIS TIME THE HOSPITAL IS PROHIBITED FROM BILLING YOU FOR THE BALANCE BASED ON ANY DIFFERENCE BETWEEN ITS BILLED CHARGES AND THE AMOUNT MEDICARE WOULD HAVE PAID.

PLAN K

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

****ONCE YOU HAVE BEEN BILLED $124 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 $124 OF MEDICARE APPROVED AMOUNTS****	$0	$0	$124 (PART B DEDUCTIBLE) ****♦
PREVENTIVE BENEFITS FOR MEDICARE COVERED SERVICES	GENERALLY 75% OR MORE OF MEDICARE APPROVED AMOUNTS	REMAINDER OF MEDICARE APPROVED AMOUNTS	ALL COSTS ABOVE MEDICARE APPROVED AMOUNTS
REMAINDER OF MEDICARE APPROVED AMOUNTS	GENERALLY 80%	GENERALLY 10%	GENERALLY 10%♦
PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)	$0	$0	ALL COSTS (AND THEY DO NOT COUNT

			TOWARD ANNUAL OUT-OF-POCKET LIMIT OF $4,000)*
BLOOD FIRST 3 PINTS	$0	50%	50%♦
NEXT $124 OF MEDICARE APPROVED AMOUNTS****	$0	$0	$124 (PART B DEDUCTIBLE) ****♦
REMAINDER OF MEDICARE APPROVED AMOUNTS	GENERALLY 80%	GENERALLY 10%	GENERALLY 10%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* THIS PLAN LIMITS YOUR ANNUAL OUT-OF-POCKET PAYMENTS FOR MEDICARE-APPROVED AMOUNTS TO $4,000 PER YEAR. HOWEVER, THIS LIMIT DOES NOT INCLUDE CHARGES FROM YOUR PROVIDER THAT EXCEED MEDICARE-APPROVED AMOUNTS (THESE ARE CALLED "EXCESS CHARGES") AND YOU WILL BE RESPONSIBLE FOR PAYING THIS DIFFERENCE IN THE AMOUNT CHARGED BY YOUR PROVIDER AND THE AMOUNT PAID BY MEDICARE FOR THE ITEM OR SERVICE.

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			

—MEDICALLY NECESSARY SKILLED CARE SERVICES AND MEDICAL SUPPLIES	100%	$0	$0
—DURABLE MEDICAL EQUIPMENT FIRST $124 OF MEDICARE APPROVED AMOUNTS*****	$0	$0	$124 (PART B DEDUCTIBLE)♦
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	10%	10%♦

*****MEDICARE BENEFITS ARE SUBJECT TO CHANGE. PLEASE CONSULT THE LATEST GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE.

PLAN L

* YOU WILL PAY ONE-FOURTH OF THE COST-SHARING OF SOME COVERED SERVICES UNTIL YOU REACH THE ANNUAL OUT-OF-POCKET LIMIT OF $2,000 EACH CALENDAR YEAR. THE AMOUNTS THAT COUNT TOWARD YOUR ANNUAL LIMIT ARE NOTED WITH DIAMONDS (♦) IN THE CHART BELOW. ONCE YOU REACH THE ANNUAL LIMIT, THE PLAN PAYS 100% OF YOUR MEDICARE COPAYMENT AND COINSURANCE FOR THE REST OF THE CALENDAR YEAR. HOWEVER, THIS LIMIT DOES NOT INCLUDE CHARGES FROM YOUR PROVIDER THAT EXCEED MEDICARE-APPROVED AMOUNTS (THESE ARE CALLED "EXCESS CHARGES") AND YOU WILL BE RESPONSIBLE FOR PAYING THIS DIFFERENCE IN THE AMOUNT CHARGED BY YOUR PROVIDER AND THE AMOUNT PAID BY MEDICARE FOR THE ITEM OR SERVICE.

PLAN L

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 $952	$714 (75% OF PART A DEDUCTI-BLE)	$238 (25% OF PART A DEDUCTIBLE)♦
61ST THRU 90TH DAY	ALL BUT $238 A DAY	$238 A DAY	$0
91ST DAY AND AFTER:			
—WHILE USING 60 LIFETIME RESERVE DAYS	ALL BUT $476 A DAY	$476 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 $119 A DAY**	**UP TO $89.25 A DAY**	**UP TO $29.75 A DAY♦**
101ST DAY AND AFTER	**$0**	**$0**	**ALL COSTS**
BLOOD			
FIRST 3 PINTS	**$0**	**75%**	**25%♦**
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	**GENERALLY, MOST MEDICARE ELIGIBLE EXPENSES FOR OUTPATIENT DRUGS AND INPATIENT RESPITE CARE**	**75% OF COINSURANCE OR COPAYMENTS**	**25% OF COINSURANCE OR COPAYMENTS♦**

*****NOTICE: WHEN YOUR MEDICARE PART A HOSPITAL BENEFITS ARE EXHAUSTED, THE INSURER STANDS IN THE PLACE OF MEDICARE AND WILL**

PAY WHATEVER AMOUNT MEDICARE WOULD HAVE PAID FOR UP TO AN ADDITIONAL 365 DAYS AS PROVIDED IN THE POLICY'S "CORE BENEFITS." DURING THIS TIME THE HOSPITAL IS PROHIBITED FROM BILLING YOU FOR THE BALANCE BASED ON ANY DIFFERENCE BETWEEN ITS BILLED CHARGES AND THE AMOUNT MEDICARE WOULD HAVE PAID.

PLAN L

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

****ONCE YOU HAVE BEEN BILLED $124 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 $124 OF MEDICARE APPROVED AMOUNTS****	$0	$0	$124 (PART B DEDUCTI-

			BLE)****♦
PREVENTIVE BENEFITS FOR MEDICARE COVERED SERVICES	GENERALLY 75% OR MORE OF MEDICARE APPROVED AMOUNTS	REMAINDER OF MEDI-CARE APPROVED AMOUNTS	ALL COSTS ABOVE MEDI-CARE APPROVED AMOUNTS
REMAINDER OF MEDICARE APPROVED AMOUNTS	GENERALLY 80%	GENERALLY 15%	GENERALLY 5%♦
PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)	$0	$0	ALL COSTS (AND THEY DO NOT COUNT TOWARD ANNUAL OUT-OF-POCKET LIMIT OF $2,000)*
BLOOD			
FIRST 3 PINTS	$0	75%	25%♦
NEXT $124 OF MEDICARE APPROVED AMOUNTS****	$0	$0	$124 (PART B DEDUCTIBLE)♦
REMAINDER OF MEDICARE APPROVED AMOUNTS	GENERALLY 80%	GENERALLY 15%	GENERALLY 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* THIS PLAN LIMITS YOUR ANNUAL OUT-OF-POCKET PAYMENTS FOR MEDICARE-APPROVED AMOUNTS TO $2,000 PER YEAR. HOWEVER, THIS LIMIT

DOES NOT INCLUDE CHARGES FROM YOUR PROVIDER THAT EXCEED MEDICARE-APPROVED AMOUNTS (THESE ARE CALLED "EXCESS CHARGES") AND YOU WILL BE RESPONSIBLE FOR PAYING THIS DIFFERENCE IN THE AMOUNT CHARGED BY YOUR PROVIDER AND THE AMOUNT PAID BY MEDICARE FOR THE ITEM OR SERVICE.

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES —MEDICALLY NECESSARY SKILLED CARE SERVICES AND MEDICAL SUPPLIES	**100%**	**$0**	**$0**
—DURABLE MEDICAL EQUIPMENT FIRST $124 OF MEDICARE APPROVED AMOUNTS	**$0**	**$0**	**$124 (PART B DEDUCTIBLE)♦**
REMAINDER OF MEDICARE APPROVED AMOUNTS	**80%**	**15%**	**5%♦**

MEDICARE BENEFITS ARE SUBJECT TO CHANGE. PLEASE CONSULT THE LATEST GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE.

Sec. 3817. (1) This section applies to medicare select policies and certificates.

(2) As used in this section:

(a) "Complaint" means any dissatisfaction expressed by an individual concerning a medicare select insurer or its network

providers.

(b) "Grievance" means a dissatisfaction expressed in writing by an individual insured under a medicare select policy or certificate with the administration, claims practices, or provision of services concerning a medicare select insurer or its network providers.

(c) "Medicare select insurer" means an insurer offering, or seeking to offer, a medicare select policy or certificate.

(d) "Medicare select policy" or "medicare select certificate" means a medicare supplement policy or certificate that contains restricted network provisions.

(e) "Network provider" means a provider of health care, or a group of providers of health care, that has entered into a written agreement with the insurer to provide benefits under a medicare select policy or certificate.

(f) "Restricted network provision" means any provision that conditions the payment of benefits, in whole or in part, on the use of network providers.

(g) "Service area" means the geographic area approved by the commissioner within which an insurer is authorized to offer a medicare select policy or certificate.

(3) A policy or certificate shall not be advertised as a medicare select policy or certificate unless it meets the requirements of this section.

(4) The commissioner may authorize an insurer to offer a medicare select policy or certificate, pursuant to this section and section 1882 of part C of title XVIII of the social security

act, ~~chapter 531, 49 Stat. 620,~~ 42 ~~U.S.C.~~ **USC** 1395ss, if the commissioner finds that the insurer has satisfied all necessary requirements.

(5) A medicare select insurer shall not issue a medicare select policy or certificate in this state until its plan of operation has been approved by the commissioner.

(6) A medicare select insurer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(a) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, as follows:

(*i*) That services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(*ii*) That the number of network providers in the service area is sufficient, with respect to current and expected policyholders, either to deliver adequately all services that are subject to a restricted network provision or to make appropriate referrals.

(*iii*) That there are written agreements with network providers describing specific responsibilities.

(*iv*) That emergency care is available 24 hours per day and 7

days per week.

(*v*) That in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a medicare select policy or certificate. This subparagraph does not apply to supplemental charges or coinsurance amounts as stated in the medicare select policy or certificate.

(b) A statement or map providing a clear description of the service area.

(c) A description of the grievance procedure to be used.

(d) A description of the quality assurance program, including all of the following:

(*i*) The formal organizational structure.

(*ii*) The written criteria for selection, retention, and removal of network providers.

(*iii*) The procedures for evaluating quality of care provided by network providers and the process to initiate corrective action if warranted.

(e) A list and description, by specialty, of the network providers.

(f) Copies of the written information proposed to be used by the insurer to comply with subsection (10).

(g) Any other information requested by the commissioner.

(7) A medicare select insurer shall file any proposed changes to the plan of operation, except for changes to the list

of network providers, with the commissioner prior to implementing any changes. An updated list of network providers shall be filed with the commissioner at least quarterly. Changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

(8) A medicare select policy or certificate shall not restrict payment for covered services provided by nonnetwork providers if the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or a condition and it is not reasonable to obtain such services through a network provider.

(9) A medicare select policy or certificate shall provide payment for full coverage under the policy or certificate for covered services that are not available through network providers.

(10) A medicare select insurer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the medicare select policy or certificate to each applicant. This disclosure shall include at least all of the following:

(a) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the medicare select policy or certificate with other medicare supplement policies or certificates offered by the insurer or offered by other insurers.

(b) A description, including address, phone number, and hours of operation, of the network providers, including primary

care physicians, specialty physicians, hospitals, and other providers.

(c) A description of the restricted network provisions, including payments for coinsurance and deductibles if providers other than network providers are utilized. **EXCEPT TO THE EXTENT SPECIFIED IN THE POLICY OR CERTIFICATE, EXPENSES INCURRED WHEN USING OUT-OF-NETWORK PROVIDERS DO NOT COUNT TOWARD THE OUT-OF-POCKET ANNUAL LIMIT CONTAINED IN PLANS K AND L.**

(d) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(e) A description of limitations on referrals to restricted network providers and to other providers.

(f) A description of the policyholder's rights to purchase any other medicare supplement policy or certificate otherwise offered by the insurer.

(g) A description of the medicare select insurer's quality assurance program and grievance procedure.

(11) Prior to the sale of a medicare select policy or certificate, a medicare select insurer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection (10) and that the applicant understands the restrictions of the medicare select policy or certificate.

(12) A medicare select insurer shall have and use procedures for hearing complaints and resolving written grievances from subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures. The

grievance procedure shall be described in the policy and certificate and in the outline of coverage. At the time the policy or certificate is issued, the insurer shall provide detailed information to the policyholder describing how a grievance may be registered with the insurer. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action. If a grievance is found to be valid, corrective action shall be taken promptly. All concerned parties shall be notified about the results of a grievance. The insurer shall report no later than each March 31 to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of those grievances.

(13) At the time of initial purchase, a medicare select insurer shall make available to each applicant for a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate otherwise offered by the insurer.

(14) At the request of an individual insured under a medicare select policy or certificate, a medicare select insurer shall make available to the individual insured the opportunity to purchase a medicare supplement policy or certificate offered by the insurer that has comparable or lesser benefits and that does not contain a restricted network provision. The insurer shall

make the policies or certificates available without requiring evidence of insurability after the medicare supplement policy or certificate has been in force for 6 months. For the purposes of this subsection, a medicare supplement policy or certificate shall be considered to have comparable or lesser benefits unless it contains 1 or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the medicare part A deductible, ~~, coverage for outpatient prescription drugs,~~ coverage for at-home recovery services, or coverage for part B excess charges.

(15) Medicare select policies and certificates shall provide for continuation of coverage if the secretary of health and human services determines that medicare select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the medicare select program to be reauthorized under law or its substantial amendment. Each medicare select insurer shall make available to each individual insured under a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate offered by the insurer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability. For the purposes of this subsection, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains 1 or more significant benefits not

included in the medicare select policy or certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the medicare part A deductible, ~~coverage for prescription drugs,~~ coverage for at-home recovery service**,** or coverage for part B excess charges.

(16) A medicare select insurer shall comply with reasonable requests for data made by state or federal agencies, including the United States department of health and human services, for the purposes of evaluating the medicare select program.

Sec. 3819. (1) An insurance policy shall not be titled, advertised, solicited, or issued for delivery in this state as a medicare supplement policy if the policy does not meet the minimum standards prescribed in this section. These minimum standards are in addition to all other requirements of this chapter.

(2) The following standards apply to medicare supplement policies:

(a) A medicare supplement policy shall not deny a claim for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than to mean a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

(b) A medicare supplement policy shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(c) A medicare supplement policy shall provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(d) A medicare supplement policy shall be guaranteed renewable. Termination shall be for nonpayment of premium or material misrepresentation only.

(e) Termination of a medicare supplement policy shall not reduce or limit the payment of benefits for any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. **RECEIPT OF MEDICARE PART D BENEFITS WILL NOT BE CONSIDERED IN DETERMINING A CONTINUOUS LOSS.**

(F) IF A MEDICARE SUPPLEMENT POLICY ELIMINATES AN OUTPATIENT PRESCRIPTION DRUG BENEFIT AS A RESULT OF REQUIREMENTS IMPOSED BY THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003, PUBLIC LAW 108-173, THE MODIFIED POLICY SHALL BE CONSIDERED TO SATISFY THE GUARANTEED RENEWAL OF THIS SUBSECTION.

(G) ~~(f)~~ A medicare supplement policy shall not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(3) A medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder or certificate holder for a period not to exceed 24 months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under medicaid, but only if the policyholder or certificate holder notifies the insurer of such assistance within 90 days after the date the individual becomes entitled to the assistance. Upon receipt of timely notice, the insurer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of medicaid eligibility, subject to adjustment for paid claims. If a suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance under medicaid, the policy shall be automatically reinstituted effective as of the date of termination of the assistance if the policyholder or certificate holder provides notice of loss of medicaid medical assistance within 90 days after the date of the loss and pays the premium attributable to the period effective as of the date of termination of the assistance. Each medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of title II of the social security act, and is covered under a group health plan as defined in section 1862(b)(1)(A)(*v*) of the social security act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan,

the policy shall be automatically reinstituted effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. All of the following apply to the reinstitution of a medicare supplement policy under this subsection:

(a) The reinstitution shall not provide for any waiting period with respect to treatment of preexisting conditions.

(b) Reinstituted coverage shall be substantially equivalent to coverage in effect before the date of the suspension. **IF THE SUSPENDED MEDICARE SUPPLEMENT POLICY PROVIDED COVERAGE FOR OUTPATIENT PRESCRIPTION DRUGS, REINSTITUTION OF THE POLICY FOR MEDICARE PART D ENROLLEES SHALL BE WITHOUT COVERAGE FOR OUTPATIENT PRESCRIPTION DRUGS AND SHALL OTHERWISE PROVIDE SUBSTANTIALLY EQUIVALENT COVERAGE TO THE COVERAGE IN EFFECT BEFORE THE DATE OF THE SUSPENSION.**

(c) Classification of premiums for reinstituted coverage shall be on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

Sec. 3823. **(1)** 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.

(2) A MEDICARE SUPPLEMENT POLICY WITH BENEFITS FOR OUTPATIENT PRESCRIPTION DRUGS IN EXISTENCE PRIOR TO JANUARY 1, 2006 SHALL BE RENEWED FOR CURRENT POLICYHOLDERS WHO DO NOT ENROLL IN PART D AT THE OPTION OF THE POLICYHOLDER.

(3) A MEDICARE SUPPLEMENT POLICY WITH BENEFITS FOR OUTPATIENT PRESCRIPTION DRUGS SHALL NOT BE ISSUED AFTER DECEMBER 31, 2005.

(4) AFTER DECEMBER 31, 2005, A MEDICARE SUPPLEMENT POLICY WITH BENEFITS FOR OUTPATIENT PRESCRIPTION DRUGS MAY NOT BE RENEWED AFTER THE POLICYHOLDER ENROLLS IN MEDICARE PART D UNLESS:

(A) THE POLICY IS MODIFIED TO ELIMINATE OUTPATIENT PRESCRIPTION COVERAGE FOR EXPENSES OF OUTPATIENT PRESCRIPTION DRUGS INCURRED AFTER THE EFFECTIVE DATE OF THE INDIVIDUAL'S COVERAGE UNDER A PART D PLAN.

(B) PREMIUMS ARE ADJUSTED TO REFLECT THE ELIMINATION OF OUTPATIENT PRESCRIPTION DRUG COVERAGE AT THE TIME OF MEDICARE PART D ENROLLMENT, ACCOUNTING FOR ANY CLAIMS PAID, IF APPLICABLE.

Sec. 3827. (1) A medicare supplement insurance policy or certificate shall not be delivered or issued for delivery in this state if the policy or certificate provides benefits that duplicate benefits provided by medicare.

(2) Application forms or a supplementary application or other form to be signed by the applicant and agent for medicare supplement policies shall include the following statements and questions designed to inform and elicit information as to whether, as of the date of the application, the applicant

CURRENTLY has ~~another~~ medicare supplement**, MEDICARE ADVANTAGE, MEDICAID COVERAGE,** or ~~other~~ **ANOTHER** health insurance policy or certificate in force or whether a medicare supplement policy or certificate is intended to replace any disability or other health policy or certificate presently in force:

[STATEMENTS]

(1) You do not need more than 1 medicare supplement policy.

(2) IF YOUR PURCHASE THIS POLICY, YOU MAY WANT TO EVALUATE YOUR EXISTING HEALTH COVERAGE AND DECIDE IF YOU NEED MULTIPLE COVERAGES.

(3) ~~(2)~~ If you are 65 or older, you may be eligible for benefits under medicaid and may not need a medicare supplement policy.

(4) ~~(3) The~~ **IF, AFTER PURCHASING THIS POLICY, YOU BECOME ELIGIBLE FOR MEDICAID, THE** benefits and premiums under your medicare supplement policy will be suspended during your entitlement to benefits under medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for medicaid. If you are no longer entitled to medicaid, your **SUSPENDED MEDICARE SUPPLEMENT POLICY, OR, IF THAT IS NO LONGER AVAILABLE, A SUBSTANTIALLY EQUIVALENT** policy**,** will be reinstituted if requested within 90 days of losing medicaid eligibility. **IF THE MEDICARE SUPPLEMENT PROVIDED COVERAGE FOR OUTPATIENT PRESCRIPTION DRUGS AND YOU ENROLLED IN MEDICARE PART D WHILE YOUR POLICY WAS SUSPENDED, THE REINSTITUTED POLICY WILL NOT HAVE OUTPATIENT PRESCRIPTION DRUG COVERAGE, BUT WILL OTHERWISE BE SUBSTANTIALLY EQUIVALENT TO YOUR COVERAGE BEFORE THE DATE OF THE**

SUSPENSION.

(5) IF YOU ARE ELIGIBLE FOR, AND HAVE ENROLLED IN, A MEDICARE SUPPLEMENT POLICY BY REASON OF DISABILITY AND YOU LATER BECOME COVERED BY AN EMPLOYER OR UNION-BASED GROUP HEALTH PLAN, THE BENEFITS AND PREMIUMS UNDER YOUR MEDICARE SUPPLEMENT POLICY CAN BE SUSPENDED, IF REQUESTED, WHILE YOU ARE COVERED UNDER THE EMPLOYER OR UNION-BASED GROUP HEALTH PLAN. IF YOU SUSPEND YOUR MEDICARE SUPPLEMENT POLICY UNDER THESE CIRCUMSTANCES, AND LATER LOSE YOUR EMPLOYER OR UNION-BASED GROUP HEALTH PLAN, YOUR SUSPENDED MEDICARE SUPPLEMENT POLICY, OR IF THAT IS NO LONGER AVAILABLE, A SUBSTANTIALLY EQUIVALENT POLICY, WILL BE REINSTITUTED IF REQUESTED WITHIN 90 DAYS OF LOSING YOUR EMPLOYER OR UNION-BASED GROUP HEALTH PLAN. IF THE MEDICARE SUPPLEMENT POLICY PROVIDED COVERAGE FOR OUTPATIENT PRESCRIPTION DRUGS AND YOU ENROLLED IN MEDICARE PART D WHILE YOUR POLICY WAS SUSPENDED, THE REINSTITUTED POLICY WILL NOT HAVE OUTPATIENT PRESCRIPTION DRUG COVERAGE, BUT WILL OTHERWISE BE SUBSTANTIALLY EQUIVALENT TO YOUR COVERAGE BEFORE THE DATE OF THE SUSPENSION.

(6) ~~(4)~~ Counseling services may be available in your state to provide advice concerning your purchase of medicare supplement insurance and concerning medicaid.

[QUESTIONS]

~~These questions should be answered to the best of your knowledge.~~

~~(1) Do you have another medicare supplement insurance policy, certificate, or contract in force (including a health care corporation certificate or health maintenance organization~~

~~contract)? If so, with which company?~~

~~(2) Do you have any other health insurance policies, certificates, or contracts that provide benefits that this medicare supplement policy would duplicate? If so, with which company? What kind of policy, certificate, or contract?~~

~~(3) If the answer to question 1 or 2 is yes, do you intend to replace these disability or health policies, certificates, or contracts with this policy or certificate?~~

~~(4) Are you covered by medicaid?~~

IF YOU LOST OR ARE LOSING OTHER HEALTH INSURANCE COVERAGE AND RECEIVED A NOTICE FROM YOUR PRIOR INSURER SAYING YOU WERE ELIGIBLE FOR GUARANTEED ISSUE OF A MEDICARE SUPPLEMENT INSURANCE POLICY, OR THAT YOU HAD CERTAIN RIGHTS TO BUY SUCH A POLICY, YOU MAY BE GUARANTEED ACCEPTANCE IN ONE OR MORE OF OUR MEDICARE SUPPLEMENT PLANS. PLEASE INCLUDE A COPY OF THE NOTICE FROM YOUR PRIOR INSURER WITH YOUR APPLICATION. PLEASE ANSWER ALL QUESTIONS.

[PLEASE MARK YES OR NO BELOW WITH AN "X"]

TO THE BEST OF YOUR KNOWLEDGE,

(1) (A) DID YOU TURN AGE 65 IN THE LAST 6 MONTHS?

YES ____ NO ____

(B) DID YOU ENROLL IN MEDICARE PART B IN THE LAST 6 MONTHS?

YES ____ NO ____

(C) IF YES, WHAT IS THE EFFECTIVE DATE? _____

(2) ARE YOU COVERED FOR MEDICAL ASSISTANCE THROUGH THE STATE MEDICAID PROGRAM?

[NOTE TO APPLICANT: IF YOU ARE PARTICIPATING IN A

"SPEND-DOWN PROGRAM" AND HAVE NOT MET YOUR "SHARE OF COST," PLEASE ANSWER NO TO THIS QUESTION.]

YES ____ NO ____

IF YES,

(A) WILL MEDICAID PAY YOUR PREMIUMS FOR THIS MEDICARE SUPPLEMENT POLICY?

YES ____ NO ____

(B) DO YOU RECEIVE ANY BENEFITS FROM MEDICAID OTHER THAN PAYMENTS TOWARD YOUR MEDICARE PART B PREMIUM?

YES ____ NO ____

(3) (A) IF YOU HAD COVERAGE FROM ANY MEDICARE PLAN OTHER THAN ORIGINAL MEDICARE WITHIN THE PAST 63 DAYS (FOR EXAMPLE, A MEDICARE ADVANTAGE PLAN, OR A MEDICARE HMO OR PPO), FILL IN YOUR START AND END DATES BELOW. IF YOU ARE STILL COVERED UNDER THIS PLAN, LEAVE "END" BLANK.

START __/__/__ END __/__/__

(B) IF YOU ARE STILL COVERED UNDER THE MEDICARE PLAN, DO YOU INTEND TO REPLACE YOUR CURRENT COVERAGE WITH THIS NEW MEDICARE SUPPLEMENT POLICY?

YES ____ NO ____

(C) WAS THIS YOUR FIRST TIME IN THIS TYPE OF MEDICARE PLAN?

YES ____ NO ____

(D) DID YOU DROP A MEDICARE SUPPLEMENT POLICY TO ENROLL IN THE MEDICARE PLAN?

YES ____ NO ____

(4) (A) DO YOU HAVE ANOTHER MEDICARE SUPPLEMENT POLICY IN FORCE?

YES ____ NO ____

(B) IF SO, WITH WHAT COMPANY, AND WHAT PLAN DO YOU

HAVE [OPTIONAL FOR DIRECT MAILERS]?

_____

(C) IF SO, DO YOU INTEND TO REPLACE YOUR CURRENT MEDICARE SUPPLEMENT POLICY WITH THIS POLICY?

YES ____ NO ____

(5) HAVE YOU HAD COVERAGE UNDER ANY OTHER HEALTH INSURANCE WITHIN THE PAST 63 DAYS? (FOR EXAMPLE, AN EMPLOYER, UNION, OR INDIVIDUAL PLAN)

YES ____ NO ____

(A) IF SO, WITH WHAT COMPANY AND WHAT KIND OF POLICY?

_____

_____

_____

_____

(B) WHAT ARE YOUR DATES OF COVERAGE UNDER THE OTHER POLICY?

START __/__/__ END __/__/__

(IF YOU ARE STILL COVERED UNDER THE OTHER POLICY, LEAVE "END" BLANK.)

(3) An agent shall list on the application form for a medicare supplement policy any other health insurance policies, certificates, or contracts he or she has sold to the applicant, including policies, certificates, or contracts sold that are still in force and policies, certificates, and contracts sold in the past 5 years that are no longer in force.

(4) For a direct response insurer, a copy of the application or supplement form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy or certificate.

(5) Upon determining that a sale will involve replacement of medicare supplement coverage, an insurer, other than a direct response insurer or its agent, shall furnish the applicant prior to issuance or delivery of the medicare supplement policy the following notice regarding replacement of medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the insurer. A direct response insurer shall deliver to the applicant at the time of issuance of the policy or certificate the following notice, regarding replacement of medicare supplement coverage. The notice regarding replacement of medicare supplement coverage shall be provided in substantially the following form and in not less than ~~10-point~~ **12-POINT** type:

"NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE ADVANTAGE
(INSURANCE COMPANY'S NAME AND ADDRESS)
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished), you intend to drop or otherwise terminate existing medicare supplement coverage **OR MEDICARE ADVANTAGE PLAN** and replace it with a policy or certificate to be issued by (company name) insurance company. Your new policy or certificate provides 30 days within which you may decide without cost whether you desire to keep the policy or certificate.

You should review this new coverage carefully comparing it

with all disability and other health coverage you now have and terminate your present coverage only if, after due consideration, you find that purchase of this medicare supplement coverage is a wise decision.

Statement to applicant by insurer, agent, or other representative:

(Use additional sheets as necessary.)

I have reviewed your current medical or health coverage. The replacement of coverage involved in this transaction does not duplicate ~~coverage~~ **YOUR EXISTING MEDICARE SUPPLEMENT, OR, IF APPLICABLE, MEDICARE ADVANTAGE COVERAGE BECAUSE YOU INTEND TO TERMINATE YOUR EXISTING MEDICARE SUPPLEMENT COVERAGE OR LEAVE YOUR MEDICARE ADVANTAGE PLAN**, to the best of my knowledge. The replacement policy is being purchased for the following reasons (check 1):

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ **MY PLAN HAS OUTPATIENT PRESCRIPTION DRUG COVERAGE AND I AM ENROLLING IN PART D**

_____ **DISENROLLMENT FROM A MEDICARE ADVANTAGE PLAN. PLEASE EXPLAIN REASON FOR DISENROLLMENT. [OPTIONAL ONLY FOR DIRECT MAILERS.]**

_____ Other. (Please specify)

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a

claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy. This paragraph may be deleted by an insurer if the replacement does not involve application of a new pre-existing condition limitation.

2. Your insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy or certificate for similar benefits to the extent such time was spent or depleted under the original coverage. This paragraph may be deleted by an insurer if the replacement does not involve application of a new preexisting condition limitation.

3. If, after thinking about it carefully, you still wish to drop your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the insurer to deny any future claims and to refund your premium as though your policy or certificate had never been in force. After the application has been completed, and before you sign it, review it carefully to be certain that all information has been properly recorded. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

4. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

Signature of Agent, Broker, or Other Representative
(* Signature not required for direct response sales.)

_____
Typed Name and Address of Agent or Broker

_____
(Date)

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

_____
(Applicant's Printed Name)

_____
(Applicant's Address)

(Policy, Certificate, or Contract Number being Replaced)"

Sec. 3830. (1) An eligible person is an individual described in subsection (2) who applies to enroll under a medicare supplement policy during the period described in subsection (3), and who submits evidence of the date of termination or disenrollment **OR MEDICARE PART D ENROLLMENT** with the application for a medicare supplement policy. For an eligible person, an insurer shall not deny or condition the issuance or effectiveness of a medicare supplement policy described in subsections (5), (6), and (7) that is offered and is available for issuance to new enrollees by the insurer, shall not discriminate in the pricing of the medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under the medicare supplement policy.

(2) An eligible person under this section is an individual

that meets any of the following:

(a) Is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under medicare and the plan terminates or the plan ceases to provide all those supplemental health benefits to the individual.

(b) Is enrolled with a ~~medicare+choice~~ **MEDICARE ADVANTAGE** organization under a ~~medicare+choice~~ **MEDICARE ADVANTAGE** plan under part C of medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a PACE provider under section 1894 of the social security act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a ~~medicare+choice~~ **MEDICARE ADVANTAGE** plan:

(*i*) The certification of the organization or plan has been terminated.

(*ii*) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(*iii*) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(b) of the social security act, where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards established under section 1856 of the social security act, or the

plan is terminated for all individuals within a residence area.

(*iv*) The individual demonstrates, in accordance with guidelines established by the secretary, that the organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide covered care in accordance with applicable quality standards, or the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

(*v*) The individual meets other exceptional conditions as the secretary may provide.

(c) Is enrolled with an eligible organization under a contract under section 1876 of the social security act, a similar organization operating under demonstration project authority, effective for periods before April 1, 1999, an organization under an agreement under section 1833(a)(1)(A) of the social security act, health care prepayment plan, or an organization under a medicare select policy, and the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subdivision (b).

(d) Is enrolled under a medicare supplement policy and the enrollment ceases because of any of the following:

(*i*) The insolvency of the insurer or bankruptcy of the noninsurer organization or of other involuntary termination of

coverage or enrollment under the policy.

(*ii*) The insurer substantially violated a material provision of the policy.

(*iii*) The insurer, or an agent or other entity acting on the insurer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

(e) Was enrolled under a medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any ~~medicare+choice~~ **MEDICARE ADVANTAGE** organization under a ~~medicare+choice~~ **MEDICARE ADVANTAGE** plan under part C of medicare, any eligible organization under a contract under section 1876 of the social security act, medicare cost, any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the social security act, or a medicare select policy; and the subsequent enrollment is terminated by the enrollee during any period within the first 12 months of the subsequent enrollment during which the enrollee is permitted to terminate the subsequent enrollment under section 1851(e) of the social security act.

(f) Upon first becoming eligible for benefits under part A of medicare at age 65, enrolls in a ~~medicare+choice~~ **MEDICARE ADVANTAGE** plan under part C of medicare, or with a PACE provider under section 1894 of the social security act, and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment.

(G) ENROLLS IN A MEDICARE PART D PLAN DURING THE INITIAL ENROLLMENT PERIOD AND, AT THE TIME OF ENROLLMENT IN PART D, WAS

ENROLLED UNDER A MEDICARE SUPPLEMENT POLICY THAT COVERS OUTPATIENT PRESCRIPTION DRUGS AND THE INDIVIDUAL TERMINATES ENROLLMENT IN THE MEDICARE SUPPLEMENT POLICY AND SUBMITS EVIDENCE OF ENROLLMENT IN MEDICARE PART D ALONG WITH THE APPLICATION FOR A POLICY DESCRIBED IN SUBSECTION (5).

(3) The guaranteed issue time periods under this section are as follows:

(a) For an individual described in subsection (2)(a), the guaranteed issue time period begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits or, if a notice is not received, notice that a claim has been denied because of a termination or cessation, **OR THE DATE THAT THE APPLICABLE COVERAGE TERMINATES OR CEASES, WHICHEVER OCCURS LATER,** and ends 63 days after ~~the~~ **THAT** date. ~~of the applicable notice.~~

(b) For an individual described in subsection (2)(b), (c), (e), or (f) whose enrollment is terminated involuntarily, the guaranteed issue time period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(c) For an individual described in subsection (2)(d)(*i*), the guaranteed issue time period begins on the earlier of the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, or the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

(d) For an individual described in subsection (2)(b), (d)(*ii*), (d)(*iii*), (e), or (f) who disenrolls voluntarily, the guaranteed issue time period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

(E) IN THE CASE OF AN INDIVIDUAL DESCRIBED IN SUBSECTION (2)(G), THE GUARANTEED ISSUE PERIOD BEGINS ON THE DATE THE INDIVIDUAL RECEIVES NOTICE PURSUANT TO SECTION 1882(V)(2)(B) OF THE SOCIAL SECURITY ACT FROM THE MEDICARE SUPPLEMENT ISSUER DURING THE 60-DAY PERIOD IMMEDIATELY PRECEDING THE INITIAL PART D ENROLLMENT PERIOD AND ENDS ON THE DATE THAT IS 63 DAYS AFTER THE EFFECTIVE DATE OF THE INDIVIDUAL'S COVERAGE UNDER MEDICARE PART D.

(F) ~~(e)~~ For an individual described in subsection (2) but not described in subdivisions (a) to (d), the guaranteed issue time period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(4) For an individual described in subsection (2)(e) whose enrollment with an organization or provider described in subsection (2)(e) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be considered an initial enrollment described in subsection (2)(e). For an individual described in subsection (2)(f) whose enrollment within a plan or in a program described in subsection (2)(f) is involuntarily terminated within the first 12 months of enrollment, and who, without an

intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be considered an initial enrollment described in subsection (2)(f). For purposes of subsections (2)(e) and (f), an enrollment of an individual with an organization or provider described in subsection (2)(e), or with a plan or provider described in subsection (2)(f), shall not be considered to be an initial enrollment after the 2-year period beginning on the date on which the individual first enrolled with such an organization, provider, or plan.

(5) ~~The~~ **SUBJECT TO THIS SUBSECTION, THE** medicare supplement policy to which an eligible person is entitled under subsection (2)(a), (b), (c), and (d) is a medicare supplement policy that has a benefit package classified as plan A, B, C, or F ~~offered by any insurer~~ **INCLUDING F WITH A HIGH DEDUCTIBLE, K, OR L OFFERED BY ANY INSURER. AFTER DECEMBER 31, 2005, IF THE INDIVIDUAL WAS MOST RECENTLY ENROLLED IN A MEDICARE SUPPLEMENT POLICY WITH AN OUTPATIENT PRESCRIPTION DRUG BENEFIT, A MEDICARE SUPPLEMENT POLICY DESCRIBED IN THIS SUBSECTION IS:**

(A) THE POLICY AVAILABLE FROM THE SAME INSURER BUT MODIFIED TO REMOVE OUTPATIENT PRESCRIPTION DRUG COVERAGE.

(B) AT THE ELECTION OF THE POLICYHOLDER, AN A, B, C, F, INCLUDING F WITH A HIGH DEDUCTIBLE, K, OR L POLICY THAT IS OFFERED BY ANY INSURER.

(6) The medicare supplement policy to which an eligible person is entitled under subsection (2)(e) is the same medicare supplement policy in which the individual was most recently previously enrolled, if available from the same insurer, or, if

not so available, a policy described in subsection (5).

(7) The medicare supplement policy to which an eligible person is entitled under subsection (2)(f) shall include any medicare supplement policy offered by any insurer.

(8) SUBSECTION (2)(G) IS A MEDICARE SUPPLEMENT POLICY THAT HAS A BENEFIT PACKAGE CLASSIFIED AS PLAN A, B, C, F, INCLUDING F WITH A HIGH DEDUCTIBLE, K, OR L, AND THAT IS OFFERED AND IS AVAILABLE FOR ISSUANCE TO NEW ENROLLEES BY THE SAME INSURER THAT ISSUED THE INDIVIDUAL'S MEDICARE SUPPLEMENT POLICY WITH OUTPATIENT PRESCRIPTION DRUG COVERAGE.

[Sec. 3831. (1) Each insurer offering individual or group expense incurred hospital, medical, or surgical policies or certificates in this state shall provide without restriction, to any person who requests coverage from an insurer and has been insured with an insurer subject to this section, if the person would no longer be insured because he or she has become eligible for medicare or if the person loses coverage under a group policy after becoming eligible for medicare, a right of continuation or conversion to their choice of the basic core benefits as described in section 3807 or a type C medicare supplemental package as described in section 3811(5)(c) that is guaranteed renewable or noncancellable. A person who is hospitalized or has been informed by a physician that he or she will require hospitalization within 30 days after the time of application shall not be entitled to coverage under this subsection until the day following the date of discharge. However, if the hospitalized person was insured by the insurer immediately prior to becoming eligible for medicare or immediately prior to losing coverage under a group policy after becoming eligible for medicare, the person shall be eligible for immediate coverage from the previous insurer under this subsection. A person shall not be entitled to a medicare supplemental policy under this subsection unless the person presents satisfactory proof to the insurer that he or she was insured with an insurer subject to this section. A person who wishes coverage under this subsection must either request coverage within 90 days before or 90 days after the month he or she becomes eligible for medicare or request coverage within 180 days after losing coverage under a group policy. A person 60 years of age or older who loses coverage under a group policy is entitled to coverage under a medicare supplemental policy without restriction from the insurer providing the former group coverage, if he or she requests coverage within 90 days before or 90 days after the month he or she becomes eligible for medicare.

(2) Except as provided in section 3833, a person not insured under an individual or group hospital, medical, or surgical expense incurred policy as specified in subsection (1), after applying for coverage under a medicare supplemental policy required to be offered under subsection (1), shall be entitled to coverage under a medicare supplemental policy that may include a provision for exclusion from preexisting conditions for 6 months after the

inception of coverage, consistent with the provisions of section 3819(2)(a).

(3) Each insurer offering individual expense incurred hospital, medical, or surgical policies in this state shall give to each person who is insured with the insurer at the time he or she becomes eligible for medicare, and to each applicant of the insurer who is eligible for medicare, written notice of the availability of coverage under this section. Each group policyholder providing hospital, medical, or surgical expense incurred coverage in this state shall give to each certificate holder who is covered at the time he or she becomes eligible for medicare, written notice of the availability of coverage under this section.

(4) NOTWITHSTANDING THE REQUIREMENTS OF THIS SECTION, AN INSURER OFFERING OR RENEWING INDIVIDUAL OR GROUP EXPENSE INCURRED HOSPITAL, MEDICAL, OR SURGICAL POLICIES OR CERTIFICATES AFTER JUNE 27, 2005 MAY COMPLY WITH THE REQUIREMENT OF PROVIDING MEDICARE SUPPLEMENTAL COVERAGE TO ELIGIBLE POLICYHOLDERS BY UTILIZING ANOTHER INSURER TO WRITE THIS COVERAGE PROVIDED THE INSURER MEETS ALL OF THE FOLLOWING REQUIREMENTS:

(A) THE INSURER PROVIDES ITS POLICYHOLDERS THE NAME OF THE INSURER THAT WILL PROVIDE THE MEDICARE SUPPLEMENTAL COVERAGE.

(B) THE INSURER GIVES ITS POLICYHOLDERS THE TELEPHONE NUMBERS AT WHICH THE MEDICARE SUPPLEMENTAL INSURER CAN BE REACHED.

(C) THE INSURER REMAINS RESPONSIBLE FOR PROVIDING MEDICARE SUPPLEMENTAL COVERAGE TO ITS POLICYHOLDERS IN THE EVENT THAT THE OTHER INSURER NO LONGER PROVIDES COVERAGE AND ANOTHER INSURER IS NOT FOUND TO TAKE ITS PLACE.

(D) THE INSURER PROVIDES CERTIFICATION FROM AN EXECUTIVE OFFICER FOR THE SPECIFIC INSURER OR AFFILIATE OF THE INSURER WISHING TO UTILIZE THIS OPTION. THIS CERTIFICATION SHALL IDENTIFY THE PROCESS PROVIDED IN SUBDIVISIONS (A) THROUGH (C) AND SHALL CLEARLY STATE THAT THE INSURER UNDERSTANDS THAT THE COMMISSIONER MAY VOID THIS ARRANGEMENT IF THE AFFILIATE FAILS TO ENSURE THAT ELIGIBLE POLICYHOLDERS ARE IMMEDIATELY OFFERED MEDICARE SUPPLEMENTAL POLICIES.

(E) THE INSURER CERTIFIES TO THE COMMISSIONER THAT IT IS IN THE PROCESS OF DISCONTINUING IN MICHIGAN ITS OFFERING OF INDIVIDUAL OR GROUP EXPENSE INCURRED HOSPITAL, MEDICAL, OR SURGICAL POLICIES OR CERTIFICATES.]

Sec. 3835. (1) Each insurer marketing medicare supplement insurance coverage in this state directly or through its agents shall do all of the following:

(a) Establish marketing procedures to ensure that any comparison of policies by its agents will be fair and accurate.

(b) Establish marketing procedures to ensure excessive insurance is not sold or issued.

(c) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant for medicare supplement insurance already has disability or other health coverage and the

types and amounts of coverage.

(d) Establish auditable procedures for verifying compliance with this subsection.

(2) In recommending the purchase or replacement of any medicare supplement coverage, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(3) Any sale of medicare supplement coverage that will provide an individual with more than 1 medicare supplement policy, certificate, or contract is prohibited.

(4) AN INSURER SHALL NOT ISSUE A MEDICARE SUPPLEMENT POLICY OR CERTIFICATE TO AN INDIVIDUAL ENROLLED IN MEDICARE ADVANTAGE UNLESS THE EFFECTIVE DATE OF THE COVERAGE IS AFTER THE TERMINATION DATE OF THE INDIVIDUAL'S MEDICARE ADVANTAGE COVERAGE.

(5) ~~(4)~~ A medical supplement policy shall display prominently by type, stamp, or other appropriate means, on the first page of the policy the following: "Notice to buyer: This policy may not cover all of your medical expenses.".

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 continuation 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) 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.

(5) IF A MEDICARE SUPPLEMENT POLICY ELIMINATES AN OUTPATIENT PRESCRIPTION DRUG BENEFIT AS A RESULT OF REQUIREMENTS IMPOSED BY THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003, PUBLIC LAW 108-173, THE MODIFIED POLICY SHALL BE CONSIDERED TO SATISFY THE GUARANTEED RENEWAL REQUIREMENTS OF THIS SECTION.

Sec. 3841. (1) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured, exercises a specifically reserved right under a medicare supplement policy, or as required to reduce or eliminate benefits to avoid duplication of medicare benefits, all riders or endorsements added to a medicare supplement policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the insured. After the date of policy issue, any

rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing and signed by the insured, unless the benefits are required minimum standards for medicare supplement policies or if the increase in benefits or coverage is required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charged shall be set forth in the policy.

(2) A medicare supplement policy shall not provide for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import.

(3) If a medicare supplement policy contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy and shall be labeled as "preexisting condition limitations".

(4) The term "medicare supplement", "medigap", "medicare wrap-around", or words of similar import shall not be used unless the policy is issued in compliance with this chapter.

(5) As soon as practicable but prior to the effective date of any changes in medicare benefits, every insurer offering medicare supplement insurance policies in this state shall file with the commissioner both of the following:

(a) Any appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies and any supporting documents necessary to justify the adjustment.

(b) Any appropriate riders, endorsements, or policy forms needed to accomplish the medicare supplement insurance modifications necessary to eliminate benefits under the policy or certificate that duplicate benefits provided by medicare. The riders, endorsements, and policy forms shall provide a clear description of the medicare supplement benefits provided by the policy.

(6) Upon satisfying the filing and approval requirements, an insurer providing medicare supplement policies delivered or issued for delivery in this state shall provide to each covered policyholder any rider, endorsement, or policy form necessary to eliminate benefits under the policy that duplicate benefits provided by medicare.

(7) As soon as practicable but no later than 30 days before the annual effective date of any medicare benefit changes, every insurer of medicare supplement policies delivered or issued for delivery in this state shall notify each covered policyholder or certificate holder of modifications made to its medicare supplement policies in a format acceptable to the commissioner. The notice shall be in outline form, contain clear and simple language, shall not contain or be accompanied by any solicitation, and shall include both of the following:

(a) A description of revisions to the medicare program and of each modification made to the coverage provided under the medicare supplement policy.

(b) Whether a premium adjustment is due to changes in medicare.

(8) INSURERS SHALL COMPLY WITH ANY NOTICE REQUIREMENTS OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003, PUBLIC LAW 108-173.

Sec. 3849. (1) An insurer shall not deliver or issue for delivery a medicare supplement policy to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

(2) AN INSURER SHALL FILE ANY RIDERS OR AMENDMENTS TO POLICY OR CERTIFICATE FORMS TO DELETE OUTPATIENT PRESCRIPTION DRUG BENEFITS AS REQUIRED BY THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003, PUBLIC LAW 108-173, ONLY WITH THE COMMISSIONER IN THE STATE IN WHICH THE POLICY OR CERTIFICATE WAS ISSUED.

(3) ~~(2)~~ An insurer shall not use or change premium rates for a medicare supplement policy unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

(4) ~~(3)~~ Except as provided in subsection ~~(4)~~ **(5)**, an insurer shall not file for approval more than 1 form of a policy or certificate for each individual policy and group policy standard medicare supplement benefit plan.

(5) ~~(4)~~ With the approval of the commissioner, an issuer may offer up to 4 additional policy forms or certificate forms of the same type for the same standard medicare supplement benefit plan, 1 for each of the following cases:

(a) The inclusion of new or innovative benefits.

(b) The addition of either direct response or agent marketing methods.

(c) The addition of either guaranteed issue or underwritten coverage.

(d) The offering of coverage to individuals eligible for medicare by reason of disability.

(6) ~~(5)~~ Except as provided in subsection ~~(6)~~ **(7)**, an insurer shall continue to make available for purchase any medicare supplement policy form or certificate form issued after the effective date of this chapter that has been approved by the commissioner. A medicare supplement policy form or certificate form shall not be considered to be available for purchase unless the insurer has actively offered it for sale in the previous 12 months.

(7) ~~(6)~~ An insurer may discontinue the availability of a medicare supplement policy form or certificate form if the insurer provides to the commissioner in writing its decision to discontinue at least 30 days prior to discontinuing the availability of the form of the medicare supplement policy. After receipt of the notice by the commissioner, the insurer shall no longer offer for sale the medicare supplement policy form or certificate form in this state.

(8) ~~(7)~~ An insurer that discontinues the availability of a medicare supplement policy form or certificate form pursuant to subsection ~~(6)~~ **(7)** shall not file for approval a new medicare supplement policy form or certificate form of the same type for

the same standard medicare supplement benefit plan as the discontinued form for a period of 5 years after the insurer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(9) ~~(8)~~ The sale or other transfer of medicare supplement business to another insurer shall be considered a discontinuance for the purposes of this section. In addition, a change in the rating structure or methodology shall be considered a discontinuance under this section unless the insurer complies with the following requirements:

(a) The insurer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing methodology and existing rates.

(b) The insurer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential that is in the public interest.

(10) ~~(9)~~ The experience of all medicare supplement policy forms or certificate forms of the same type in a standard medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in section 3853 except that forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other

forms for purposes of the refund or credit calculation.

(11) ~~(10)~~ Each insurer that issues medicare supplement policies for delivery in this state shall comply with sections 1842 and 1882 of title XVIII of the social security act, ~~chapter 531, 49 Stat. 620,~~ 42 ~~U.S.C.~~ **USC** 1395u and 1395ss, and shall certify that compliance on the medicare supplement insurance experience reporting form.

(12) ~~(11)~~ For the purposes of this section, "type" means an individual policy, a group policy, an individual medicare select policy, or a group medicare select policy.

Enacting section 1. Sections 451 to 499a of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1451 to 550.1499a, are repealed.