

SENATE BILL No. 1056

February 22, 2006, Introduced by Senator CHERRY and referred to the Committee on Health Policy.

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, 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, 500.3835, 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, 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:

- 1 Sec. 3801. As used in this chapter:
- 2 (a) "Applicant" means:

1 (i) For an individual medicare supplement policy, the person
2 who seeks to contract for ~~insurance~~ benefits.

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

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

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

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

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

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

20 (i) A group health plan.

21 (ii) Health insurance coverage.

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

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

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

27 (vi) A medical care program of the Indian health service or

- 1 of a tribal organization.
- 2 (vii) A state health benefits risk pool.
- 3 (viii) A health plan offered under chapter 89 of title 5 of
4 the United States Code, 5 ~~U.S.C.~~ **USC** 8901 to 8914.
- 5 (ix) A public health plan as defined in federal regulation.
- 6 (x) Health care under section 5(e) of title I of the peace
7 corps act, ~~Public Law 87-293,~~ 22 ~~U.S.C.~~ **USC** 2504.
- 8 (g) "Direct response solicitation" means solicitation in
9 which an insurer representative does not contact the applicant in
10 person and explain the coverage available, such as, but not
11 limited to, solicitation through direct mail or through
12 advertisements in periodicals and other media.
- 13 (h) "Employee welfare benefit plan" means a plan, fund, or
14 program of employee benefits as defined in section 3 of subtitle
15 A of title I of the employee retirement income security act of
16 1974, ~~Public Law 93-406,~~ 29 ~~U.S.C.~~ **USC** 1002.
- 17 (i) "Insolvency" means when an insurer licensed to transact
18 the business of insurance in this state has had a final order of
19 liquidation entered against it with a finding of insolvency by a
20 court of competent jurisdiction in the insurer's state of
21 domicile.
- 22 (j) "Insurer" includes any entity, including a health care
23 corporation **OPERATING PURSUANT TO THE NONPROFIT HEALTH CARE**
24 **CORPORATION REFORM ACT, 1980 PA 350, MCL 550.1101 TO 550.1704,**
25 delivering or issuing for delivery in this state medicare
26 supplement policies.
- 27 (k) "Medicaid" means title XIX of the social security act,

1 ~~chapter 531, 49 Stat. 620, 42 U.S.C. USC 1396 to 1396r-6 and~~
 2 ~~1396r-8 to 1396v.~~

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

8 (m) ~~"Medicare+choice plan"~~ **"MEDICARE ADVANTAGE"** means a
 9 plan of coverage for health benefits under medicare part C as
 10 defined in section 12-2859 of part C of medicare, 42 ~~U.S.C. USC~~
 11 1395w-28, and includes any of the following:

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

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

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

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

27 (o) "Medicare supplement policy" means an individual,

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

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

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

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

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

25 **SEC. 3804. THIS CHAPTER APPLIES TO A MEDICARE SUPPLEMENT**
26 **POLICY DELIVERED, ISSUED FOR DELIVERY, OR RENEWED BY A HEALTH**
27 **CARE CORPORATION OPERATING PURSUANT TO THE NONPROFIT HEALTH CARE**

1 CORPORATION REFORM ACT, 1980 PA 350, MCL 550.1101 TO 550.1704, ON
2 OR AFTER THE EFFECTIVE DATE OF THIS SECTION.

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

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

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

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

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

24 (e) "Nurses" may be defined so that the description of nurse
25 is to a type of nurse, such as a registered professional nurse or
26 a licensed practical nurse. If the words "nurse", "trained
27 nurse", or "registered nurse" are used without specific

1 instruction, then the use of those terms requires the insurer to
2 recognize the services of any individual who qualifies under
3 those terms in accordance with the public health code, ~~Act No.~~
4 ~~368 of the Public Acts of 1978, being sections 333.1101 to~~
5 ~~333.25211 of the Michigan Compiled Laws~~ 1978 PA 368, MCL
6 333.1101 TO 333.25211.

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

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

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

18 Sec. 3807. (1) Every insurer issuing a medicare supplement
19 insurance policy in this state shall make available a medicare
20 supplement insurance policy that includes a basic core package of
21 benefits to each prospective insured. An insurer issuing a
22 medicare supplement insurance policy in this state may make
23 available to prospective insureds benefits pursuant to section
24 3809 that are in addition to, but not instead of, the basic core
25 package. The basic core package of benefits shall include all of
26 the following:

27 (a) Coverage of part A medicare eligible expenses for

1 hospitalization to the extent not covered by medicare from the
2 61st day through the 90th day in any medicare benefit period.

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

6 (c) Upon exhaustion of the medicare hospital inpatient
7 coverage including the lifetime reserve days, coverage of **100% OF**
8 the medicare part A eligible expenses for hospitalization paid at
9 the ~~diagnostic related group day outlier per diem~~ **APPLICABLE**
10 **PROSPECTIVE PAYMENT SYSTEM RATE** or other appropriate **MEDICARE**
11 standard of payment, subject to a lifetime maximum benefit of an
12 additional 365 days.

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

17 (e) Coverage for the coinsurance amount, or the copayment
18 amount paid for hospital outpatient department services under a
19 prospective payment system, of medicare eligible expenses under
20 part B regardless of hospital confinement, subject to the
21 medicare part B deductible.

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

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

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

1 (ii) COVERAGE OF 100% OF THE PART A HOSPITAL COINSURANCE
2 AMOUNT FOR EACH MEDICARE LIFETIME INPATIENT RESERVE DAY USED FROM
3 THE NINETY-FIRST DAY THROUGH THE ONE HUNDRED FIFTIETH DAY IN ANY
4 MEDICARE BENEFIT PERIOD.

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

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

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

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

26 (vii) COVERAGE FOR 50%, UNDER MEDICARE PART A OR B, OF THE
27 REASONABLE COST OF THE FIRST 3 PINTS OF BLOOD OR EQUIVALENT

1 QUANTITIES OF PACKED RED BLOOD CELLS, AS DEFINED UNDER FEDERAL
2 REGULATIONS, UNLESS REPLACED IN ACCORDANCE WITH FEDERAL
3 REGULATIONS UNTIL THE OUT-OF-POCKET LIMITATION IS MET AS
4 DESCRIBED IN SUBPARAGRAPH (x).

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

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

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

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

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

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

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

1 Sec. 3809. (1) In addition to the basic core package of
2 benefits required under section 3807, the following benefits may
3 be included in a medicare supplement insurance policy and if
4 included shall conform to section 3811(5)(b) to (j):

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

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

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

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

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

26 (f) Basic outpatient prescription drug benefit: coverage for
27 50% of outpatient prescription drug charges, after a \$250.00

1 calendar year deductible, to a maximum of \$1,250.00 in benefits
2 received by the insured per calendar year, to the extent not
3 covered by medicare. **THE OUTPATIENT PRESCRIPTION DRUG BENEFIT MAY**
4 **BE INCLUDED FOR SALE OR ISSUANCE IN A MEDICARE SUPPLEMENT POLICY**
5 **UNTIL JANUARY 1, 2006.**

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

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

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

27 (i) An annual clinical preventive medical history and

1 physical examination that may include tests and services from
 2 subparagraph (ii) and patient education to address preventive
 3 health care measures.

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

8 ~~—— (A) Digital rectal examination.~~

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

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

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

14 ~~—— (E) Thyroid function test.~~

15 ~~—— (F) Diabetes screening.~~

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

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

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

1 medicare or other government programs and care provided by family
2 members, unpaid volunteers, or providers who are not care
3 providers. Coverage is limited to:

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

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

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

12 (iv) Seven visits in any 1 week.

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

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

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

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

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

1 **INNOVATIVE** benefits may include benefits that are appropriate to
2 medicare supplement insurance, new or innovative, not otherwise
3 available, cost-effective, and offered in a manner that is
4 consistent with the goal of simplification of medicare supplement
5 policies. **AFTER DECEMBER 31, 2005, THE INNOVATIVE BENEFIT SHALL**
6 **NOT INCLUDE AN OUTPATIENT PRESCRIPTION DRUG BENEFIT.**

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

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

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

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

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

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

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

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

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

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

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

26 (a) A standardized medicare supplement benefit plan A shall
27 be limited to the basic core benefits common to all benefit plans

1 as defined in section 3807.

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

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

12 (d) A standardized medicare supplement benefit plan D shall
13 include only the following: the core benefits as defined in
14 section 3807, the medicare part A deductible, skilled nursing
15 facility care, medically necessary emergency care in a foreign
16 country, and the at-home recovery benefit as defined in section
17 3809(1)(a), (b), (h), and (j).

18 (e) A standardized medicare supplement benefit plan E shall
19 include only the following: the core benefits as defined in
20 section 3807, the medicare part A deductible, skilled nursing
21 facility care, medically necessary emergency care in a foreign
22 country, and preventive medical care as defined in section
23 3809(1)(a), (b), (h), and (i).

24 (f) A standardized medicare supplement benefit plan F shall
25 include only the following: the core benefits as defined in
26 section 3807, the medicare part A deductible, skilled nursing
27 facility care, medicare part B deductible, 100% of the medicare

1 part B excess charges, and medically necessary emergency care in
2 a foreign country as defined in section 3809(1)(a), (b), (c),
3 (e), and (h). A standardized medicare supplement plan F high
4 deductible shall include only the following: 100% of covered
5 expenses following the payment of the annual high deductible plan
6 F deductible. The covered expenses include the core benefits as
7 defined in section 3807, plus the medicare part A deductible,
8 skilled nursing facility care, the medicare part B deductible,
9 100% of the medicare part B excess charges, and medically
10 necessary emergency care in a foreign country as defined in
11 section 3809(1)(a), (b), (c), (e), and (h). The annual high
12 deductible plan F deductible shall consist of out-of-pocket
13 expenses, other than premiums, for services covered by the
14 medicare supplement plan F policy, and shall be in addition to
15 any other specific benefit deductibles. The annual high
16 deductible plan F deductible is \$1,580.00 for calendar year 2001,
17 and the secretary shall adjust it annually thereafter to reflect
18 the change in the consumer price index for all urban consumers
19 for the 12-month period ending with August of the preceding year,
20 rounded to the nearest multiple of \$10.00.

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

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

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

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

1 expenses following the payment of the annual high deductible plan
2 J deductible. The covered expenses include the core benefits as
3 defined in section 3807, plus the medicare part A deductible,
4 skilled nursing facility care, medicare part B deductible, 100%
5 of the medicare part B excess charges, extended outpatient
6 prescription drug benefit, medically necessary emergency care in
7 a foreign country, preventive medical care benefit and at-home
8 recovery benefit as defined in section 3809(1)(a), (b), (c), (e),
9 (g), (h), (i), and (j). The annual high deductible plan J
10 deductible shall consist of out-of-pocket expenses, other than
11 premiums, for services covered by the medicare supplement plan J
12 policy, and shall be in addition to any other specific benefit
13 deductibles. The annual deductible shall be \$1,580.00 for
14 calendar year 2001, and the secretary shall adjust it annually
15 thereafter to reflect the change in the consumer price index for
16 all urban consumers for the 12-month period ending with August of
17 the preceding year, rounded to the nearest multiple of \$10.00.

18 **THE OUTPATIENT DRUG BENEFIT SHALL NOT BE INCLUDED IN A MEDICARE**
19 **SUPPLEMENT POLICY SOLD AFTER DECEMBER 31, 2005.**

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

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

24 Sec. 3815. (1) An insurer that offers a medicare supplement
25 policy shall provide to the applicant at the time of application
26 an outline of coverage and, except for direct response
27 solicitation policies, shall obtain an acknowledgment of receipt

1 of the outline of coverage from the applicant. The outline of
2 coverage provided to applicants pursuant to this section shall
3 consist of the following 4 parts:

4 (a) A cover page.

5 (b) Premium information.

6 (c) Disclosure pages.

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

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

12 **(3) —(2)—** If an outline of coverage is provided at the time
13 of application and the medicare supplement policy or certificate
14 is issued on a basis that would require revision of the outline,
15 a substitute outline of coverage properly describing the policy
16 or certificate shall accompany the policy or certificate when it
17 is delivered and shall contain the following statement, in no
18 less than 12-point type, immediately above the company name:

19 NOTICE: Read this outline of coverage carefully.

20 It is not identical to the outline of coverage
21 provided upon application and the coverage
22 originally applied for has not been issued.

23 **(4) —(3)—** An outline of coverage under subsection (1) shall
24 be in the language and format prescribed in this section and in
25 not less than 12-point type. The A through ~~J~~ L letter
26 designation of the plan shall be shown on the cover page and the

1 plans offered by the insurer shall be prominently identified.
 2 Premium information shall be shown on the cover page or
 3 immediately following the cover page and shall be prominently
 4 displayed. The premium and method of payment mode shall be stated
 5 for all plans that are offered to the applicant. All possible
 6 premiums for the applicant shall be illustrated. The following
 7 items shall be included in the outline of coverage in the order
 8 prescribed below and in substantially the following form, as
 9 approved by the commissioner:

10 (Insurer Name)
 11 Medicare Supplement Coverage
 12 Outline of Medicare Supplement Coverage-Cover Page:
 13 Benefit Plan(s) _____ [insert letter(s) of plan(s) being offered]
 14 Medicare supplement insurance can be sold in only ~~10~~ 12
 15 standard plans plus 2 high deductible plans. This chart shows
 16 the benefits included in each plan. Every insurer shall make
 17 available Plan "A". Some plans may not be available in your
 18 state.
 19 **BASIC BENEFITS:** Included in All Plans.
 20 Hospitalization: Part A coinsurance plus coverage for 365
 21 additional days after Medicare benefits end.
 22 Medical Expenses: Part B coinsurance (20% of Medicare-approved
 23 expenses) or, for hospital outpatient department services under
 24 a prospective payment system, applicable copayments.
 25 Blood: First three pints of blood each year.

	A	B	C	D	E	F F*	G	H	I	J J*
1										
2	X	X	X	X	X	X	X	X	X	X
3										
4			X	X	X	X	X	X	X	X
5		X	X	X	X	X	X	X	X	X
6			X			X				X
7						X	X		X	X
8						100%	80%		100%	100%
9										
10			X	X	X	X	X	X	X	X
11				X			X		X	X
12										
13								⌘ \$1,250 Limit	⌘ \$1,250 Limit	⌘ \$3,000 Limit
14										
15					X					X

1 [COMPANY NAME]

2 OUTLINE OF MEDICARE SUPPLEMENT COVERAGE - COVER PAGE 2

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

		K**	L**
1			
2		100% OF PART A HOSPITALIZA- TION COINSURANCE PLUS COVERAGE FOR 365 DAYS AFTER MEDICARE BENEFITS END	100% OF PART A HOSPITALIZA- TION COINSURANCE PLUS COVERAGE FOR 365 DAYS AFTER MEDICARE BENEFITS END
3			
4			
5			
6	BASIC BENEFITS	50% HOSPICE COST-SHARING	75% HOSPICE COST-SHARING
7		50% OF MEDICARE-ELIGIBLE EXPENSES FOR THE FIRST THREE PINTS OF BLOOD	75% OF MEDICARE-ELIGIBLE EXPENSES FOR THE FIRST THREE PINTS OF BLOOD
8			
9			
10		50% PART B COINSURANCE, EXCEPT 100% COINSURANCE FOR PART B PREVENTIVE SERVICES	75% PART B COINSURANCE, EXCEPT 100% COINSURANCE FOR PART B PREVENTIVE SERVICES
11			
12			
13	SKILLED NURSING	50% SKILLED NURSING	75% SKILLED NURSING
14	COINSURANCE	FACILITY COINSURANCE	FACILITY COINSURANCE
15	PART A DEDUCTIBLE	50% PART A DEDUCTIBLE	75% PART A DEDUCTIBLE
16	PART B DEDUCTIBLE		
17	PART B EXCESS (100%)		
18	FOREIGN TRAVEL		
19	EMERGENCY		
20	AT-HOME RECOVERY		
21	PREVENTIVE CARE NOT		

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

1 *PLANS F AND J ALSO HAVE AN OPTION CALLED A HIGH DEDUCTIBLE PLAN
2 F AND A HIGH DEDUCTIBLE PLAN J. THESE HIGH DEDUCTIBLE PLANS PAY
3 THE SAME BENEFITS AS PLANS F AND J AFTER ONE HAS PAID A CALENDAR
4 YEAR [\$1,730] DEDUCTIBLE. BENEFITS FROM HIGH DEDUCTIBLE PLANS F
5 AND J WILL NOT BEGIN UNTIL OUT-OF-POCKET EXPENSES EXCEED
6 [\$1,730]. OUT-OF-POCKET EXPENSES FOR THIS DEDUCTIBLE ARE EXPENSES
7 THAT WOULD ORDINARILY BE PAID BY THE POLICY. THESE EXPENSES
8 INCLUDE THE MEDICARE DEDUCTIBLES FOR PART A AND PART B, BUT DO
9 NOT INCLUDE THE PLAN'S SEPARATE FOREIGN TRAVEL EMERGENCY
10 DEDUCTIBLE.

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

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

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

21 SEE OUTLINES OF COVERAGE FOR DETAILS AND EXCEPTIONS.

22 PREMIUM INFORMATION

23 We (insert insurer's name) can only raise your premium if we
24 raise the premium for all policies like yours in this state. (If
25 the premium is based on the increasing age of the insured,

1 include information specifying when premiums will change).

2 DISCLOSURES

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

5 READ YOUR POLICY VERY CAREFULLY

6 This is only an outline describing your policy's most
7 important features. The policy is your insurance contract. You
8 must read the policy itself to understand all of the rights and
9 duties of both you and your insurance company.

10 RIGHT TO RETURN POLICY

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

16 POLICY REPLACEMENT

17 If you are replacing another health insurance policy, do not
18 cancel it until you have actually received your new policy and
19 are sure you want to keep it.

20 NOTICE

1 This policy may not fully cover all of your medical costs.

2 [For agent issued policies]

3 Neither (insert insurer's name) nor its agents are connected
4 with medicare.

5 [For direct response issued policies]

6 (Insert insurer's name) is not connected with medicare.

7 This outline of coverage does not give all the details of
8 medicare coverage. Contact your local social security office or
9 consult "the medicare handbook" for more details.

10 COMPLETE ANSWERS ARE VERY IMPORTANT

11 When you fill out the application for the new policy, be
12 sure to answer truthfully and completely all questions about your
13 medical and health history. The company may cancel your policy
14 and refuse to pay any claims if you leave out or falsify
15 important medical information. [If the policy or certificate is
16 guaranteed issue, this paragraph need not appear.]

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

19 [Include for each plan offered by the insurer a chart
20 showing the services, medicare payments, plan payments, and
21 insured payments using the same language, in the same order, and
22 using uniform layout and format as shown in the charts that
23 follow. An insurer may use additional benefit plan designations
24 on these charts pursuant to section 3809(1)(k). Include an
25 explanation of any innovative benefits on the cover page and in

1 the chart, in a manner approved by the commissioner. The insurer
 2 issuing the policy shall change the dollar amounts each year to
 3 reflect current figures. No more than 4 plans may be shown on 1
 4 chart.] Charts for each plan are as follows:

5 PLAN A

6 MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

7 *A benefit period begins on the first day you receive service
 8 as an inpatient in a hospital and ends after you have been out of
 9 the hospital and have not received skilled care in any other
 10 facility for 60 days in a row.

11	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
12	HOSPITALIZATION*			
13	Semiprivate room and			
14	board, general nursing			
15	and miscellaneous			
16	services and supplies			
17	First 60 days	All but \$792 \$912	\$0	\$792— \$912 (Part A Deductible)
18				
19	61st thru 90th day	All but \$198 \$228	\$198— \$228	\$0
20	a day		a day	
21	91st day and after:			
22	—While using 60			
23	lifetime reserve days	All but \$396 \$456	\$396— \$456	\$0
24	a day		a day	
25	—Once lifetime reserve			

1	days are used:			
2	-Additional 365 days	\$0	100% of	\$0
3			Medicare	
4			Eligible	
5			Expenses	
6	-Beyond the			
7	Additional 365 days	\$0	\$0	All Costs
8	SKILLED NURSING FACILITY			
9	CARE*			
10	You must meet Medicare's			
11	requirements, including			
12	having been in a hospital			
13	for at least 3 days and			
14	entered a Medicare-			
15	approved facility within			
16	30 days after leaving the			
17	hospital			
18	First 20 days	All approved		
19		amounts	\$0	\$0
20	21st thru 100th day	All but \$99		Up to \$99
21		\$114	\$0	\$114
22	101st day and after	a day		a day
23		\$0	\$0	All costs
24	BLOOD			
25	First 3 pints	\$0	3 pints	\$0
26	Additional amounts	100%	\$0	\$0
27	HOSPICE CARE			
28	Available as long as your	All but very	\$0	Balance
29	doctor certifies you are	limited		
30	terminally ill and you	coinsurance		
	elect to receive these	for outpatient		

1	services	drugs and		
2		inpatient		
3		respite care		

4 PLAN A
5 MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

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

9	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
10	MEDICAL EXPENSES—			
11	In or out of the hospital			
12	and outpatient hospital			
13	treatment, such as			
14	Physician's services,			
15	inpatient and outpatient			
16	medical and surgical			
17	services and supplies,			
18	physical and speech			
19	therapy, diagnostic			
20	tests, durable medical			
21	equipment,			
22	First \$100 of Medicare			
23	Approved Amounts*	\$0	\$0	\$100 (Part B
24				Deductible)
25	Remainder of Medicare			
26	Approved Amounts	80%	20%	\$0
27	Part B Excess Charges			
28	(Above Medicare			

1	Approved Amounts)	\$0	\$0	All Costs
2	BLOOD			
3	First 3 pints	\$0	All Costs	\$0
4	Next \$100 of Medicare			
5	Approved Amounts*	\$0	\$0	\$100 (Part B
6				Deductible)
7	Remainder of Medicare			
8	Approved Amounts	80%	20%	\$0
9	CLINICAL LABORATORY			
10	SERVICES—			
11	Blood tests TESTS for			
12	diagnostic services	100%	\$0	\$0

13 PARTS A & B

14	HOME HEALTH CARE			
15	Medicare Approved			
16	Services			
17	—Medically necessary			
18	skilled care services			
19	and medical supplies	100%	\$0	\$0
20	—Durable medical			
21	equipment			
22	First \$100 of Medicare			
23	Approved Amounts*	\$0	\$0	\$100 (Part B
24				Deductible)
25	Remainder of Medicare			
26	Approved Amounts	80%	20%	\$0

27 PLAN B

28 MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

1 *A benefit period begins on the first day you receive service
 2 as an inpatient in a hospital and ends after you have been out of
 3 the hospital and have not received skilled care in any other
 4 facility for 60 days in a row.

5	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
6	HOSPITALIZATION*			
7	Semiprivate room and			
8	board, general nursing			
9	and miscellaneous			
10	services and supplies			
11	First 60 days	All but \$792 \$912	\$792 \$912	\$0
12			(Part A	
13			Deductible)	
14	61st thru 90th day	All but \$198 \$228	\$198 \$228	\$0
15		a day	a day	
16	91st day and after			
17	-While using 60			
18	lifetime reserve days	All but \$396 \$456	\$396 \$456	\$0
19		a day	a day	
20	-Once lifetime reserve			
21	days are used:			
22	-Additional 365 days	\$0	100% of	\$0
23			Medicare	
24			Eligible	
25			Expenses	
26	-Beyond the			
27	Additional 365 days	\$0	\$0	All Costs

1 SKILLED NURSING FACILITY
2 CARE*
3 You must meet Medicare's
4 requirements, including
5 having been in a hospital
6 for at least 3 days and
7 entered a Medicare-
8 approved facility within
9 30 days after leaving the
10 hospital

11	First 20 days	All approved amounts	\$0	\$0
12				
13	21st thru 100th day	All but \$99 \$114	\$0	Up to \$99 \$114
14		a day		a day
15	101st day and after	\$0	\$0	All costs
16	BLOOD			
17	First 3 pints	\$0	3 pints	\$0
18	Additional amounts	100%	\$0	\$0
19	HOSPICE CARE			
20	Available as long as your	All but very	\$0	Balance
21	doctor certifies you are	limited		
22	terminally ill and you	coinsurance		
23	elect to receive these	for outpatient		
24	services	drugs and		
25		inpatient		
26		respite care		

27 PLAN B
28 MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

29 *Once you have been billed \$100 of Medicare-Approved amounts

1 for covered services (which are noted with an asterisk), your
 2 Part B Deductible will have been met for the calendar year.

3	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
4	MEDICAL EXPENSES—			
5	In or out of the hospital			
6	and outpatient hospital			
7	treatment, such as			
8	Physician's services,			
9	inpatient and outpatient			
10	medical and surgical			
11	services and supplies,			
12	physical and speech			
13	therapy, diagnostic			
14	tests, durable medical			
15	equipment,			
16	First \$100 of Medicare			
17	Approved Amounts*	\$0	\$0	\$100 (Part B
18				Deductible)
19	Remainder of Medicare			
20	Approved Amounts	80%	20%	\$0
21	Part B Excess Charges			
22	(Above Medicare			
23	Approved Amounts)	\$0	\$0	All Costs
24	BLOOD			
25	First 3 pints	\$0	All Costs	\$0
26	Next \$100 of Medicare			
27	Approved Amounts*	\$0	\$0	\$100 (Part B
28				Deductible)
29	Remainder of Medicare			
30	Approved Amounts	80%	20%	\$0

1 CLINICAL LABORATORY
 2 SERVICES—
 3 ~~Blood tests~~ **TESTS** for
 4 diagnostic services 100% \$0 \$0

5 PARTS A & B

6	HOME HEALTH CARE			
7	Medicare Approved			
8	Services			
9	—Medically necessary			
10	skilled care services			
11	and medical supplies	100%	\$0	\$0
12	—Durable medical			
13	equipment			
14	First \$100 of			
15	Medicare			
16	Approved Amounts*	\$0	\$0	\$100 (Part B
17				Deductible)
18	Remainder of Medicare			
19	Approved Amounts	80%	20%	\$0

20 PLAN C

21 MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

22 *A benefit period begins on the first day you receive service
 23 as an inpatient in a hospital and ends after you have been out of
 24 the hospital and have not received skilled care in any other
 25 facility for 60 days in a row.

26	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
----	----------	---------------	-----------	---------

1	HOSPITALIZATION*			
2	Semiprivate room and			
3	board, general nursing			
4	and miscellaneous			
5	services and supplies			
6	First 60 days	All but \$792 \$912	\$792 \$912	\$0
7			(Part A	
8			Deductible)	
9	61st thru 90th day	All but \$198 \$228	\$198 \$228	\$0
10		a day	a day	
11	91st day and after			
12	-While using 60			
13	lifetime reserve days	All but \$396 \$456	\$396 \$456	\$0
14		a day	a day	
15	-Once lifetime reserve			
16	days are used:			
17	-Additional 365 days	\$0	100% of	\$0
18			Medicare	
19			Eligible	
20			Expenses	
21	-Beyond the			
22	Additional 365 days	\$0	\$0	All Costs
23	SKILLED NURSING FACILITY			
24	CARE*			
25	You must meet Medicare's			
26	requirements, including			
27	having been in a hospital			
28	for at least 3 days and			
29	entered a Medicare-			

1	approved facility within			
2	30 days after leaving the			
3	hospital			
4	First 20 days	All approved		
5		amounts	\$0	\$0
6	21st thru 100th day	All but \$99	Up to \$99	
7		\$114	\$114	\$0
8	101st day and after	a day	a day	
9		\$0	\$0	All costs
10	BLOOD			
11	First 3 pints	\$0	3 pints	\$0
12	Additional amounts	100%	\$0	\$0
13	HOSPICE CARE			
14	Available as long as your	All but very	\$0	Balance
15	doctor certifies you are	limited		
16	terminally ill and you	coinsurance		
17	elect to receive these	for outpatient		
18	services	drugs and		
19		inpatient		
		respite care		

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—			
In or out of the hospital			

1	and outpatient hospital			
2	treatment, such as			
3	Physician's services,			
4	inpatient and outpatient			
5	medical and surgical			
6	services and supplies,			
7	physical and speech			
8	therapy, diagnostic			
9	tests, durable medical			
10	equipment,			
11	First \$100 of Medicare			
12	Approved Amounts*	\$0	\$100	\$0
13			(Part B	
14			Deductible)	
15	Remainder of Medicare			
16	Approved Amounts	80%	20%	\$0
17	Part B Excess Charges			
18	(Above Medicare			
19	Approved Amounts)	\$0	\$0	All Costs
20	BLOOD			
21	First 3 pints	\$0	All Costs	\$0
22	Next \$100 of Medicare			
23	Approved Amounts*	\$0	\$100	\$0
24			(Part B	
25			Deductible)	
26	Remainder of Medicare			
27	Approved Amounts	80%	20%	\$0
28	CLINICAL LABORATORY			
29	SERVICES—			
30	Blood tests TESTS for			
31	diagnostic services	100%	\$0	\$0

1

PARTS A & B

2	HOME HEALTH CARE			
3	Medicare Approved			
4	Services			
5	–Medically necessary			
6	skilled care services			
7	and medical supplies	100%	\$0	\$0
8	–Durable medical			
9	equipment			
10	First \$100 of Medicare			
11	Approved Amounts*	\$0	\$100	\$0
12			(Part B	
13			Deductible)	
14	Remainder of Medicare			
15	Approved Amounts	80%	20%	\$0

16

OTHER BENEFITS—NOT COVERED BY MEDICARE

17	FOREIGN TRAVEL—			
18	Not covered by Medicare			
19	Medically necessary			
20	emergency care services			
21	beginning during the			
22	first 60 days of each			
23	trip outside the USA			
24	First \$250 each			
25	calendar year	\$0	\$0	\$250
26	Remainder of charges	\$0	80% to a	20% and
27			lifetime	amounts
28			maximum	over the
29			benefit	\$50,000

1		of \$50,000	lifetime
2			maximum

3 PLAN D

4 MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

5 *A benefit period begins on the first day you receive service
6 as an inpatient in a hospital and ends after you have been out of
7 the hospital and have not received skilled care in any other
8 facility for 60 days in a row.

9	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
10	HOSPITALIZATION*			
11	Semiprivate room and			
12	board, general nursing			
13	and miscellaneous			
14	services and supplies			
15	First 60 days	All but \$792 \$912	\$792 \$912	\$0
16			(Part A	
17			Deductible)	
18	61st thru 90th day	All but \$198 \$228	\$198 \$228	\$0
19		a day	a day	
20	91st day and after			
21	—While using 60			
22	lifetime reserve days	All but \$396 \$456	\$396 \$456	\$0
23		a day	a day	
24	—Once lifetime reserve			
25	days are used:			

1	-Additional 365 days	\$0	100% of	\$0
2			Medicare	
3			Eligible	
4			Expenses	
5	-Beyond the			
6	Additional 365 days	\$0	\$0	All Costs
7	SKILLED NURSING FACILITY			
8	CARE*			
9	You must meet Medicare's			
10	requirements, including			
11	having been in a hospital			
12	for at least 3 days and			
13	entered a Medicare-			
14	approved facility within			
15	30 days after leaving the			
16	hospital			
17	First 20 days	All approved		
18		amounts	\$0	\$0
19	21st thru 100th day	All but \$99	Up to \$99	\$0
20		\$114	\$114	
21	101st day and after	a day	a day	
22		\$0	\$0	All costs
23	BLOOD			
24	First 3 pints	\$0	3 pints	\$0
25	Additional amounts	100%	\$0	\$0
26	HOSPICE CARE			
27	Available as long as your	All but very	\$0	Balance
28	doctor certifies you are	limited		
29	terminally ill and you	coinsurance		
30	elect to receive these	for outpatient		
	services	drugs and		

	inpatient		
	respite care		

3 PLAN D
 4 MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

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

8 SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
9 MEDICAL EXPENSES—			
10 In or out of the hospital			
11 and outpatient hospital			
12 treatment, such as			
13 Physician's services,			
14 inpatient and outpatient			
15 medical and surgical			
16 services and supplies,			
17 physical and speech			
18 therapy, diagnostic			
19 tests, durable medical			
20 equipment,			
21 First \$100 of Medicare			
22 Approved Amounts*	\$0	\$0	\$100
23			(Part B
24			Deductible)
25 Remainder of Medicare			
26 Approved Amounts	80%	20%	\$0
27 Part B Excess Charges			
28 (Above Medicare			

1	Approved Amounts)	\$0	\$0	All Costs
2	BLOOD			
3	First 3 pints	\$0	All Costs	\$0
4	Next \$100 of Medicare			
5	Approved Amounts*	\$0	\$0	\$100
6				(Part B
7				Deductible)
8	Remainder of Medicare			
9	Approved Amounts	80%	20%	\$0
10	CLINICAL LABORATORY			
11	SERVICES—			
12	Blood tests TESTS for			
13	diagnostic services	100%	\$0	\$0
14	PARTS A & B			
15	HOME HEALTH CARE			
16	Medicare Approved			
17	Services			
18	—Medically necessary			
19	skilled care services			
20	and medical supplies	100%	\$0	\$0
21	—Durable medical			
22	equipment			
23	First \$100 of Medicare			
24	Approved Amounts*	\$0	\$0	\$100
25				(Part B
26				Deductible)
27	Remainder of Medicare			
28	Approved Amounts	80%	20%	\$0
29	AT-HOME RECOVERY			
30	SERVICES—			

1	Not covered by Medicare			
2	Home care certified by			
3	your doctor, for personal			
4	care during recovery from			
5	an injury or sickness for			
6	which Medicare approved a			
7	Home Care Treatment Plan			
8	-Benefit for each visit	\$0	Actual	
9			Charges to	
10			\$40 a visit	Balance
11	-Number of visits			
12	covered (must be			
13	received within 8			
14	weeks of last			
15	Medicare Approved			
16	visit)	\$0	Up to the	
17			number of	
18			Medicare	
19			Approved	
20			visits, not	
21			to exceed 7	
22			each week	
23	-Calendar year maximum	\$0	\$1,600	

24 OTHER BENEFITS—NOT COVERED BY MEDICARE

25	FOREIGN TRAVEL—			
26	Not covered by Medicare			
27	Medically necessary			
28	emergency care services			
29	beginning during the			
30	first 60 days of each			

1	trip outside the USA			
2	First \$250 each			
3	calendar year	\$0	\$0	\$250
4	Remainder of charges	\$0	80% to a	20% and
5			lifetime	amounts
6			maximum	over the
7			benefit	\$50,000
8			of \$50,000	lifetime
9				maximum

10

PLAN E

11

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

12

*A benefit period begins on the first day you receive service

13

as an inpatient in a hospital and ends after you have been out of

14

the hospital and have not received skilled care in any other

15

facility for 60 days in a row.

16	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
17	HOSPITALIZATION*			
18	Semiprivate room and			
19	board, general nursing			
20	and miscellaneous			
21	services and supplies			
22	First 60 days	All but \$792 \$912	\$792 \$912	\$0
23			(Part A	
24			Deductible)	
25	61st thru 90th day	All but \$198 \$228	\$198 \$228	\$0
26		a day	a day	

1	91st day and after			
2	-While using 60			
3	lifetime reserve days	All but \$396 \$456	\$396 — \$456	\$0
4		a day	a day	
5	-Once lifetime reserve			
6	days are used:			
7	-Additional 365 days	\$0	100% of	\$0
8			Medicare	
9			Eligible	
10			Expenses	
11	-Beyond the			
12	Additional 365 days	\$0	\$0	All Costs
13	SKILLED NURSING FACILITY			
14	CARE*			
15	You must meet Medicare's			
16	requirements, including			
17	having been in a hospital			
18	for at least 3 days and			
19	entered a Medicare-			
20	approved facility within			
21	30 days after leaving the			
22	hospital			
23	First 20 days	All approved		
24		amounts	\$0	\$0
25	21st thru 100th day	All but \$99 \$114	Up to \$99 \$114	\$0
26		a day	a day	
27	101st day and after	\$0	\$0	All costs
28	BLOOD			
29	First 3 pints	\$0	3 pints	\$0
30	Additional amounts	100%	\$0	\$0

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

9

PLAN E

10

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

11

*Once you have been billed \$100 of Medicare-Approved amounts

12

for covered services (which are noted with an asterisk), your

13

Part B Deductible will have been met for the calendar year.

14	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
15	MEDICAL EXPENSES—			
16	In or out of the hospital			
17	and outpatient hospital			
18	treatment, such as			
19	Physician's services,			
20	inpatient and outpatient			
21	medical and surgical			
22	services and supplies,			
23	physical and speech			
24	therapy, diagnostic			
25	tests, durable medical			
26	equipment,			
27	First \$100 of Medicare			
28	Approved Amounts*	\$0	\$0	\$100

1				(Part B
2				Deductible)
3	Remainder of Medicare			
4	Approved Amounts	80%	20%	\$0
5	Part B Excess Charges			
6	(Above Medicare			
7	Approved Amounts)	\$0	\$0	All Costs
8	BLOOD			
9	First 3 pints	\$0	All Costs	\$0
10	Next \$100 of Medicare			
11	Approved Amounts*	\$0	\$0	\$100
12				(Part B
13				Deductible)
14	Remainder of Medicare			
15	Approved Amounts	80%	20%	\$0
16	CLINICAL LABORATORY			
17	SERVICES—			
18	Blood tests for			
19	diagnostic services	100%	\$0	\$0

20 PARTS A & B

21	HOME HEALTH CARE			
22	Medicare Approved			
23	Services			
24	—Medically necessary			
25	skilled care services			
26	and medical supplies	100%	\$0	\$0
27	—Durable medical			
28	equipment			
29	First \$100 of Medicare			
30	Approved Amounts*	\$0	\$0	\$100

1			(Part B
2			Deductible)
3	Remainder of Medicare		
4	Approved Amounts	80%	20%
			\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

6	FOREIGN TRAVEL—			
7	Not covered by Medicare			
8	Medically necessary			
9	emergency care services			
10	beginning during the			
11	first 60 days of each			
12	trip outside the USA			
13	First \$250 each			
14	calendar year	\$0	\$0	\$250
15	Remainder of Charges	\$0	80% to a	20% and
16			lifetime	amounts
17			maximum	over the
18			benefit	\$50,000
19			of \$50,000	lifetime
20				maximum
21	PREVENTIVE MEDICAL CARE			
22	BENEFIT—			
23	Not covered by Medicare			
24	Annual physical and			
25	preventive tests and			
26	services such as: fecal			
27	occult blood test,			
28	digital rectal exam,			
29	mammogram, hearing			
30	screening, dipstick			

1	urinalysis, diabetes			
2	screening, thyroid			
3	function test, influenza			
4	shot, tetanus and			
5	diphtheria booster and			
6	education, administered			
7	or ordered by your			
8	doctor when not covered			
9	by Medicare			
10	First \$120 each			
11	calendar year	\$0	\$120	\$0
12	Additional charges	\$0	\$0	All Costs

13 PLAN F OR HIGH DEDUCTIBLE PLAN F
 14 MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

15 *A benefit period begins on the first day you receive service
 16 as an inpatient in a hospital and ends after you have been out of
 17 the hospital and have not received skilled care in any other
 18 facility for 60 days in a row.

19 **This high deductible plan pays the same or offers the same
 20 benefits as plan F after you have paid a calendar year ~~—(\$1,580)~~
 21 **(\$1,730)** deductible. Benefits from the high deductible plan F
 22 will not begin until out-of-pocket expenses are ~~—\$1,580—~~ **\$1,730**.
 23 Out-of-pocket expenses for this deductible are expenses that
 24 would ordinarily be paid by the policy. This includes medicare
 25 deductibles for part A and part B, but does not include the
 26 plan's separate foreign travel emergency deductible.

1	SERVICES	MEDICARE	AFTER YOU	IN ADDITION
2		PAYS	PAY \$1,580 \$1,730	TO \$1,580 \$1,730
3			DEDUCTIBLE**,	DEDUCTIBLE**,
4			PLAN PAYS	YOU PAY
5	HOSPITALIZATION*			
6	Semiprivate room and			
7	board, general nursing			
8	and miscellaneous			
9	services and supplies			
10	First 60 days	All but \$792 \$912	\$792 \$912	\$0
11			(Part A	
12			Deductible)	
13	61st thru 90th day	All but \$198 \$228	\$198 \$228	\$0
14		a day	a day	
15	91st day and after			
16	-While using 60			
17	lifetime reserve days	All but \$396 \$438	\$396 \$438	\$0
18		a day	a day	
19	-Once lifetime reserve			
20	days are used:			
21	-Additional 365 days	\$0	100% of	\$0
22			Medicare	
23			Eligible	
24			Expenses	
25	-Beyond the			
26	Additional 365 days	\$0	\$0	All Costs
27	SKILLED NURSING FACILITY			
28	CARE*			
29	You must meet Medicare's			

1			Deductible)	
2	Remainder of Medicare			
3	Approved Amounts	80%	20%	\$0
4	Part B Excess Charges			
5	(Above Medicare			
6	Approved Amounts)	\$0	100%	\$0
7	BLOOD			
8	First 3 pints	\$0	All Costs	\$0
9	Next \$100 of Medicare			
10	Approved Amounts*	\$0	\$100	\$0
11			(Part B	
12			Deductible)	
13	Remainder of Medicare			
14	Approved Amounts	80%	20%	\$0
15	CLINICAL LABORATORY			
16	SERVICES—			
17	Blood tests TESTS for			
18	diagnostic services	100%	\$0	\$0

19 PARTS A & B

20	HOME HEALTH CARE			
21	Medicare Approved			
22	Services			
23	—Medically necessary			
24	skilled care services			
25	and medical supplies	100%	\$0	\$0
26	—Durable medical			
27	equipment			
28	First \$100 of Medicare			
29	Approved Amounts*	\$0	\$100	\$0
30			(Part B	

1			Deductible)	
2	Remainder of Medicare			
3	Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

5	FOREIGN TRAVEL—			
6	Not covered by Medicare			
7	Medically necessary			
8	emergency care services			
9	beginning during the			
10	first 60 days of each			
11	trip outside the USA			
12	First \$250 each			
13	calendar year	\$0	\$0	\$250
14	Remainder of charges	\$0	80% to a	20% and
15			lifetime	amounts
16			maximum	over the
17			benefit	\$50,000
18			of \$50,000	lifetime
19				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.

26	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
----	----------	---------------	-----------	---------

1	HOSPITALIZATION*			
2	Semiprivate room and			
3	board, general nursing			
4	and miscellaneous			
5	services and supplies			
6	First 60 days	All but \$792 \$912	\$792 \$912	\$0
7			(Part A	
8			Deductible)	
9	61st thru 90th day	All but \$198 \$228	\$198 \$228	\$0
10	a day		a day	
11	91st day and after			
12	-While using 60			
13	lifetime reserve days	All but \$396 \$456	\$396 \$456	\$0
14	a day		a day	
15	-Once lifetime reserve			
16	days are used:			
17	-Additional 365 days	\$0	100% of	\$0
18			Medicare	
19			Eligible	
20			Expenses	
21	-Beyond the			
22	Additional 365 days	\$0	\$0	All Costs
23	SKILLED NURSING FACILITY			
24	CARE*			
25	You must meet Medicare's			
26	requirements, including			
27	having been in a hospital			
28	for at least 3 days and			
29	entered a Medicare-			

1	approved facility within			
2	30 days after leaving the			
3	hospital			
4	First 20 days	All approved		
5		amounts	\$0	\$0
6	21st thru 100th day	All but \$99	Up to \$99	
7		\$114	\$114	\$0
8	101st day and after	a day	a day	
9		\$0	\$0	All costs
10	BLOOD			
11	First 3 pints	\$0	3 pints	\$0
12	Additional amounts	100%	\$0	\$0
13	HOSPICE CARE			
14	Available as long as your	All but very	\$0	Balance
15	doctor certifies you are	limited		
16	terminally ill and you	coinsurance		
17	elect to receive these	for outpatient		
18	services	drugs and		
19		inpatient		
		respite care		

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—			
In or out of the hospital			

1	and outpatient hospital			
2	treatment, such as			
3	Physician's services,			
4	inpatient and outpatient			
5	medical and surgical			
6	services and supplies,			
7	physical and speech			
8	therapy, diagnostic			
9	tests, durable medical			
10	equipment,			
11	First \$100 of Medicare			
12	Approved Amounts*	\$0	\$0	\$100
13				(Part B
14				Deductible)
15	Remainder of Medicare			
16	Approved Amounts	80%	20%	\$0
17	Part B Excess Charges			
18	(Above Medicare			
19	Approved Amounts)	\$0	80%	20%
20	BLOOD			
21	First 3 pints	\$0	All Costs	\$0
22	Next \$100 of Medicare			
23	Approved Amounts*	\$0	\$0	\$100
24				(Part B
25				Deductible)
26	Remainder of Medicare			
27	Approved Amounts	80%	20%	\$0
28	CLINICAL LABORATORY			
29	SERVICES—			
30	Blood tests TESTS for			
31	diagnostic services	100%	\$0	\$0

1

PARTS A & B

2	HOME HEALTH CARE			
3	Medicare Approved			
4	Services			
5	-Medically necessary			
6	skilled care services			
7	and medical supplies	100%	\$0	\$0
8	-Durable medical			
9	equipment			
10	First \$100 of Medicare			
11	Approved Amounts*	\$0	\$0	\$100
12				(Part B
13				Deductible)
14	Remainder of Medicare			
15	Approved Amounts	80%	20%	\$0
16	AT-HOME RECOVERY			
17	SERVICES-			
18	Not covered by Medicare			
19	Home care certified by			
20	your doctor, for personal			
21	care during recovery from			
22	an injury or sickness for			
23	which Medicare approved a			
24	Home Care Treatment Plan			
25	-Benefit for each visit	\$0	Actual	
26			Charges to	
27			\$40 a visit	Balance
28	-Number of visits			
29	covered (must be			
30	received within 8			

1	weeks of last			
2	Medicare Approved			
3	visit)	\$0	Up to the	
4			number of	
5			Medicare	
6			Approved	
7			visits, not	
8			to exceed 7	
9			each week	
10	-Calendar year maximum	\$0	\$1,600	

11 OTHER BENEFITS—NOT COVERED BY MEDICARE

12	FOREIGN TRAVEL—			
13	Not covered by Medicare			
14	Medically necessary			
15	emergency care services			
16	beginning during the			
17	first 60 days of each			
18	trip outside the USA			
19	First \$250 each			
20	calendar year	\$0	\$0	\$250
21	Remainder of charges	\$0	80% to a	20% and
22			lifetime	amounts
23			maximum	over the
24			benefit	\$50,000
25			of \$50,000	lifetime
26				maximum

27 PLAN H

28 MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

1 *A benefit period begins on the first day you receive service
 2 as an inpatient in a hospital and ends after you have been out of
 3 the hospital and have not received skilled care in any other
 4 facility for 60 days in a row.

5	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
6	HOSPITALIZATION*			
7	Semiprivate room and			
8	board, general nursing			
9	and miscellaneous			
10	services and supplies			
11	First 60 days	All but \$792 \$912	\$792 \$912	\$0
12			(Part A	
13			Deductible)	
14	61st thru 90th day	All but \$198 \$228	\$198 \$228	\$0
15		a day	a day	
16	91st day and after			
17	-While using 60			
18	lifetime reserve days	All but \$396 \$456	\$396 \$456	\$0
19		a day	a day	
20	-Once lifetime reserve			
21	days are used:			
22	-Additional 365 days	\$0	100% of	\$0
23			Medicare	
24			Eligible	
25			Expenses	
26	-Beyond the			
27	Additional 365 days	\$0	\$0	All Costs
28	SKILLED NURSING FACILITY			

1	CARE*			
2	You must meet Medicare's			
3	requirements, including			
4	having been in a hospital			
5	for at least 3 days and			
6	entered a Medicare-			
7	approved facility within			
8	30 days after leaving the			
9	hospital			
10	First 20 days	All approved		
11		amounts	\$0	\$0
12	21st thru 100th day	All but \$99	Up to \$99	
13		\$114	\$114	\$0
14	101st day and after	a day	a day	
15		\$0	\$0	All costs
16	BLOOD			
17	First 3 pints	\$0	3 pints	\$0
18	Additional amounts	100%	\$0	\$0
19	HOSPICE CARE			
20	Available as long as your	All but very	\$0	Balance
21	doctor certifies you are	limited		
22	terminally ill and you	coinsurance		
23	elect to receive these	for outpatient		
24	services	drugs and		
25		inpatient		
		respite care		

26 PLAN H

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

28 *Once you have been billed \$100 of Medicare-Approved amounts
 29 for covered services (which are noted with an asterisk), your

1 Part B Deductible will have been met for the calendar year.

2	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
3	MEDICAL EXPENSES—			
4	In or out of the hospital			
5	and outpatient hospital			
6	treatment, such as			
7	Physician's services,			
8	inpatient and outpatient			
9	medical and surgical			
10	services and supplies,			
11	physical and speech			
12	therapy, diagnostic			
13	tests, durable medical			
14	equipment,			
15	First \$100 of Medicare			
16	Approved Amounts*	\$0	\$0	\$100
17				(Part B
18				Deductible)
19	Remainder of Medicare			
20	Approved Amounts	80%	20%	\$0
21	Part B Excess Charges			
22	(Above Medicare			
23	Approved Amounts)	\$0	\$0	All Costs
24	BLOOD			
25	First 3 pints	\$0	All Costs	\$0
26	Next \$100 of Medicare			
27	Approved Amounts*	\$0	\$0	\$100
28				(Part B
29				Deductible)

1	Remainder of Medicare			
2	Approved Amounts	80%	20%	\$0
3	CLINICAL LABORATORY			
4	SERVICES—			
5	Blood tests TESTS for			
6	diagnostic services	100%	\$0	\$0

7 PARTS A & B

8	HOME HEALTH CARE			
9	Medicare Approved			
10	Services			
11	—Medically necessary			
12	skilled care services			
13	and medical supplies	100%	\$0	\$0
14	—Durable medical			
15	equipment			
16	First \$100 of Medicare			
17	Approved Amounts*	\$0	\$0	\$100
18				(Part B
19				Deductible)
20	Remainder of Medicare			
21	Approved Amounts	80%	20%	\$0

22 OTHER BENEFITS—NOT COVERED BY MEDICARE

23	FOREIGN TRAVEL—			
24	Not covered by Medicare			
25	Medically necessary			
26	emergency care services			
27	beginning during the			
28	first 60 days of each			
29	trip outside the USA			

1	First \$250 each			
2	calendar year	\$0	\$0	\$250
3	Remainder of Charges	\$0	80% to a	20% and
4			lifetime	amounts
5			maximum	over the
6			benefit	\$50,000
7			of \$50,000	lifetime
8				maximum
9	BASIC OUTPATIENT PRE-			
10	SCRIPTION DRUGS-			
11	Not covered by Medicare			
12	— First \$250 each			
13	— calendar year	\$0	\$0	\$250
14	— Next \$2,500 each			
15	— calendar year	\$0	50% \$1,250	50%
16			calendar	
17			year	
18			maximum	
19			benefit	
20	Over \$2,500 each			
21	calendar year	\$0	\$0	All Costs

22

PLAN I

23

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

24

*A benefit period begins on the first day you receive service

25

as an inpatient in a hospital and ends after you have been out of

26

the hospital and have not received skilled care in any other

27

facility for 60 days in a row.

1	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
2	HOSPITALIZATION*			
3	Semiprivate room and			
4	board, general nursing			
5	and miscellaneous			
6	services and supplies			
7	First 60 days	All but \$792 \$912	\$792 \$912	\$0
8			(Part A	
9			Deductible)	
10	61st thru 90th day	All but \$198 \$228	\$198 \$228	\$0
11		a day	a day	
12	91st day and after			
13	-While using 60			
14	lifetime reserve days	All but \$396 \$456	\$396 \$456	\$0
15		a day	a day	
16	-Once lifetime reserve			
17	days are used:			
18	-Additional 365 days	\$0	100% of	\$0
19			Medicare	
20			Eligible	
21			Expenses	
22	-Beyond the			
23	Additional 365 days	\$0	\$0	All Costs
24	SKILLED NURSING FACILITY			
25	CARE*			
26	You must meet Medicare's			
27	requirements, including			
28	having been in a hospital			
29	for at least 3 days and			

1	entered a Medicare-			
2	approved facility within			
3	30 days after leaving the			
4	hospital			
5	First 20 days	All approved		
6		amounts	\$0	\$0
7	21st thru 100th day	All but \$99	Up to \$99	
8		\$114	\$114	\$0
9	101st day and after	a day	a day	
		\$0	\$0	All costs
10	BLOOD			
11	First 3 pints	\$0	3 pints	\$0
12	Additional amounts	100%	\$0	\$0
13	HOSPICE CARE			
14	Available as long as your	All but very	\$0	Balance
15	doctor certifies you are	limited		
16	terminally ill and you	coinsurance		
17	elect to receive these	for outpatient		
18	services	drugs and		
19		inpatient		
20		respite care		

PLAN I

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

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

	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
26				
27	MEDICAL EXPENSES—			

1	In or out of the hospital			
2	and outpatient hospital			
3	treatment, such as			
4	Physician's services,			
5	inpatient and outpatient			
6	medical and surgical			
7	services and supplies,			
8	physical and speech			
9	therapy, diagnostic			
10	tests, durable medical			
11	equipment,			
12	First \$100 of Medicare			
13	Approved Amounts*	\$0	\$0	\$100
14				(Part B
15				Deductible)
16	Remainder of Medicare			
17	Approved Amounts	80%	20%	\$0
18	Part B Excess Charges			
19	(Above Medicare			
20	Approved Amounts)	\$0	100%	\$0
21	BLOOD			
22	First 3 pints	\$0	All Costs	\$0
23	Next \$100 of Medicare			
24	Approved Amounts*	\$0	\$0	\$100
25				(Part B
26				Deductible)
27	Remainder of Medicare			
28	Approved Amounts	80%	20%	\$0
29	CLINICAL LABORATORY			
30	SERVICES—			
31	Blood tests TESTS for			

1	diagnostic services	100%	\$0	\$0
2	PARTS A & B			
3	HOME HEALTH CARE			
4	Medicare Approved			
5	Services			
6	-Medically necessary			
7	skilled care services			
8	and medical supplies	100%	\$0	\$0
9	-Durable medical			
10	equipment			
11	First \$100 of Medicare			
12	Approved Amounts*	\$0	\$0	\$100
13				(Part B
14				Deductible)
15	Remainder of Medicare			
16	Approved Amounts	80%	20%	\$0
17	AT-HOME RECOVERY			
18	SERVICES-			
19	Not covered by Medicare			
20	Home care certified by			
21	your doctor, for personal			
22	care during recovery from			
23	an injury or sickness for			
24	which Medicare approved a			
25	Home Care Treatment Plan			
26	-Benefit for each visit	\$0	Actual	
27			Charges to	
28			\$40 a visit	Balance
29	-Number of visits			
30	covered (must be			

1	received within 8			
2	weeks of last			
3	Medicare Approved			
4	visit)	\$0	Up to the	
5			number of	
6			Medicare	
7			Approved	
8			visits, not	
9			to exceed 7	
10			each week	
11	-Calendar year maximum	\$0	\$1,600	

12 OTHER BENEFITS—NOT COVERED BY MEDICARE

13	FOREIGN TRAVEL—			
14	Not covered by Medicare			
15	Medically necessary			
16	emergency care services			
17	beginning during the			
18	first 60 days of each			
19	trip outside the USA			
20	First \$250 each			
21	calendar year	\$0	\$0	\$250
22	Remainder of Charges*	\$0	80% to a	20% and
23			lifetime	amounts
24			maximum	over the
25			benefit	\$50,000
26			of \$50,000	lifetime
27				maximum
28	BASIC OUTPATIENT PRE-			
29	SCRIPTION DRUGS—			
30	Not covered by Medicare			

1	— First \$250 each			
2	— calendar year	\$0	\$0	\$250
3	— Next \$2,500 each			
4	— calendar year	\$0	50% \$1,250	50%
5			calendar	
6			year	
7			maximum	
8			benefit	
9	— Over \$2,500 each			
10	— calendar year	\$0	\$0	All Costs

11 PLAN J OR HIGH DEDUCTIBLE PLAN J
 12 MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

13 *A benefit period begins on the first day you receive service
 14 as an inpatient in a hospital and ends after you have been out of
 15 the hospital and have not received skilled care in any other
 16 facility for 60 days in a row.

17 **This high deductible plan pays the same or offers the same
 18 benefits as plan J after you have paid a calendar year ~~—(\$1,580)~~
 19 **(\$1,730)** deductible. Benefits from the high deductible plan J
 20 will not begin until out-of-pocket expenses are ~~—\$1,580~~ **\$1,730**.
 21 Out-of-pocket expenses for this deductible are expenses that
 22 would ordinarily be paid by the policy. This includes medicare
 23 deductibles for part A and part B, but does not include the
 24 plan's **OUTPATIENT PRESCRIPTION DRUG DEDUCTIBLE OR** separate
 25 foreign travel emergency deductible.

26	SERVICES	MEDICARE PAYS	AFTER YOU	IN ADDITION
----	----------	---------------	-----------	-------------

1			PAY \$1,580 \$1,730	TO \$1,580 \$1,730
2			DEDUCTIBLE**,	DEDUCTIBLE**,
3			PLAN PAYS	YOU PAY
4	HOSPITALIZATION*			
5	Semiprivate room and			
6	board, general nursing			
7	and miscellaneous			
8	services and supplies			
9	First 60 days	All but \$792 \$912	\$792— \$912	\$0
10			(Part A	
11			Deductible)	
12	61st thru 90th day	All but \$198 \$228	\$198— \$228	\$0
13		a day	a day	
14	91st day and after			
15	-While using 60			
16	lifetime reserve days	All but \$396 \$456	\$396— \$456	\$0
17		a day	a day	
18	-Once lifetime reserve			
19	days are used:			
20	-Additional 365 days	\$0	100% of	\$0
21			Medicare	
22			Eligible	
23			Expenses	
24	-Beyond the			
25	Additional 365 days	\$0	\$0	All Costs
26	SKILLED NURSING FACILITY			
27	CARE*			

1	You must meet Medicare's			
2	requirements, including			
3	having been in a hospital			
4	for at least 3 days and			
5	entered a Medicare-			
6	approved facility within			
7	30 days after leaving the			
8	hospital			
9	First 20 days	All approved		
10		amounts	\$0	\$0
11	21st thru 100th day	All but \$99 \$114	Up to \$99 \$114	\$0
12		a day	a day	
13	101st day and after	\$0	\$0	All costs
14	BLOOD			
15	First 3 pints	\$0	3 pints	\$0
16	Additional amounts	100%	\$0	\$0
17	HOSPICE CARE			
18	Available as long as your	All but very	\$0	Balance
19	doctor certifies you are	limited		
20	terminally ill and you	coinsurance		
21	elect to receive these	for outpatient		
22	services	drugs and		
23		inpatient		
24		respite care		

PLAN J

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

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

1 **This high deductible plan pays the same or offers the same
 2 benefits as plan J after you have paid a calendar year ~~—(\$1,580)~~
 3 **(\$1,730)** deductible. Benefits from the high deductible plan J
 4 will not begin until out-of-pocket expenses are ~~—\$1,580~~ **\$1,730**.
 5 Out-of-pocket expenses for this deductible are expenses that
 6 would ordinarily be paid by the policy. This includes medicare
 7 deductibles for part A and part B, but does not include the
 8 plan's separate **OUTPATIENT PRESCRIPTION DRUG DEDUCTIBLE OR**
 9 foreign travel emergency deductible.

10 11 12 13	SERVICES	MEDICARE PAYS	AFTER YOU PAY \$1,580 \$1,730 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$1,580 \$1,730 DEDUCTIBLE**, YOU PAY
14 15 16 17 18 19 20 21 22 23 24 25 26	MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare			

1	Approved Amounts*	\$0	\$100	\$0
2			(Part B	
3			Deductible)	
4	Remainder of Medicare			
5	Approved Amounts	80%	20%	\$0
6	Part B Excess Charges			
7	(Above Medicare			
8	Approved Amounts)	\$0	100%	\$0
9	BLOOD			
10	First 3 pints	\$0	All Costs	\$0
11	Next \$100 of Medicare			
12	Approved Amounts*	\$0	\$100	\$0
13			(Part B	
14			Deductible)	
15	Remainder of Medicare			
16	Approved Amounts	80%	20%	\$0
17	CLINICAL LABORATORY			
18	SERVICES—			
19	Blood tests for			
20	diagnostic services	100%	\$0	\$0

21 PARTS A & B

22	HOME HEALTH CARE			
23	Medicare Approved			
24	Services			
25	—Medically necessary			
26	skilled care services			
27	and medical supplies	100%	\$0	\$0
28	—Durable medical			
29	equipment			
30	First \$100 of Medicare			

1	Approved Amounts*	\$0	\$100	\$0
2			(Part B	
3			Deductible)	
4	Remainder of Medicare			
5	Approved Amounts	80%	20%	\$0
6	AT-HOME RECOVERY			
7	SERVICES—			
8	Not covered by Medicare			
9	Home care certified by			
10	your doctor, for personal			
11	care beginning during			
12	recovery from an injury			
13	or sickness for which			
14	Medicare approved a			
15	Home Care Treatment Plan			
16	-Benefit for each visit	\$0	Actual	
17			Charges to	
18			\$40 a visit	Balance
19	-Number of visits			
20	covered (must be			
21	received within 8			
22	weeks of last visit)			
23	Medicare Approved	\$0	Up to the	
24			number of	
25			Medicare	
26			Approved	
27			visits, not	
28			to exceed 7	
29			each week	
30	-Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

1			
2	FOREIGN TRAVEL—		
3	Not covered by Medicare		
4	Medically necessary		
5	emergency care services		
6	beginning during the		
7	first 60 days of each		
8	trip outside the USA		
9	First \$250 each		
10	calendar year	\$0	\$0
11	Remainder of Charges	\$0	80% to a
12			lifetime
13			maximum
14			benefit
15			of \$50,000
16			\$250
17	EXTENDED OUTPATIENT PRE-		
18	SCRIPTION DRUGS—		
19	Not covered by Medicare		
20	—First \$250 each		
21	—calendar year	\$0	\$0
22	—Next \$6,000 each		\$250
23	—calendar year	\$0	50% \$3,000
24			50%
25			calendar
26			year
27			maximum
28	—Over \$6,000 each		benefit
29	—calendar year	\$0	\$0
30	PREVENTIVE MEDICAL CARE		All Costs

1	BENEFIT-			
2	Not covered by Medicare			
3	Annual physical and			
4	preventive tests and			
5	services such as: fecal			
6	occult blood test,			
7	digital rectal exam,			
8	mammogram, hearing			
9	screening, dipstick			
10	urinalysis, diabetes			
11	screening, thyroid			
12	function test, influenza			
13	shot, tetanus and			
14	diphtheria booster and			
15	education, administered			
16	or ordered by your doctor			
17	when not covered by			
18	Medicare			
19	First \$120 each			
20	calendar year	\$0	\$120	\$0
21	Additional charges	\$0	\$0	All costs

22 **PLAN K**

23 *** YOU WILL PAY HALF THE COST-SHARING OF SOME COVERED SERVICES**

24 **UNTIL YOU REACH THE ANNUAL OUT-OF-POCKET LIMIT OF \$4,000 EACH**

25 **CALENDAR YEAR. THE AMOUNTS THAT COUNT TOWARD YOUR ANNUAL LIMIT**

26 **ARE NOTED WITH DIAMONDS (◆) IN THE CHART BELOW. ONCE YOU REACH**

27 **THE ANNUAL LIMIT, THE PLAN PAYS 100% OF YOUR MEDICARE COPAYMENT**

28 **AND COINSURANCE FOR THE REST OF THE CALENDAR YEAR. HOWEVER, THIS**

29 **LIMIT DOES NOT INCLUDE CHARGES FROM YOUR PROVIDER THAT EXCEED**

1 MEDICARE-APPROVED AMOUNTS (THESE ARE CALLED "EXCESS CHARGES") AND
 2 YOU WILL BE RESPONSIBLE FOR PAYING THIS DIFFERENCE IN THE AMOUNT
 3 CHARGED BY YOUR PROVIDER AND THE AMOUNT PAID BY MEDICARE FOR THE
 4 ITEM OR SERVICE.

5 PLAN K

6 MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

7 **A BENEFIT PERIOD BEGINS ON THE FIRST DAY YOU RECEIVE
 8 SERVICE AS AN INPATIENT IN A HOSPITAL AND ENDS AFTER YOU HAVE
 9 BEEN OUT OF THE HOSPITAL AND HAVE NOT RECEIVED SKILLED CARE IN
 10 ANY OTHER FACILITY FOR 60 DAYS IN A ROW.

11	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
12	HOSPITALIZATION**			
13	SEMIPRIVATE ROOM AND			
14	BOARD, GENERAL NURSING			
15	AND MISCELLANEOUS			
16	SERVICES AND SUPPLIES			
17	FIRST 60 DAYS	ALL BUT \$912	\$456 (50%	\$456 (50% OF
18			OF PART A	PART A
19			DEDUCTI-	DEDUCTIBLE) ◆
20			BLE)	
21				
22	61ST THRU 90TH DAY	ALL BUT \$228	\$228	\$0
23		A DAY	A DAY	
24	91ST DAY AND AFTER:			
25	—WHILE USING 60			
26	LIFETIME RESERVE DAYS	ALL BUT \$456	\$456	\$0

1		A DAY	A DAY	
2	-ONCE LIFETIME RESERVE			
3	DAYS ARE USED:			
4	-ADDITIONAL 365 DAYS	\$0	100% OF	\$0***
5			MEDICARE	
6			ELIGIBLE	
7			EXPENSES	
8	-BEYOND THE			
9	ADDITIONAL 365 DAYS	\$0	\$0	ALL COSTS
10	SKILLED NURSING FACILITY			
11	CARE**			
12	YOU MUST MEET MEDICARE'S			
13	REQUIREMENTS, INCLUDING			
14	HAVING BEEN IN A HOSPITAL			
15	FOR AT LEAST 3 DAYS AND			
16	ENTERED A MEDICARE-			
17	APPROVED FACILITY WITHIN			
18	30 DAYS AFTER LEAVING THE			
19	HOSPITAL			
20	FIRST 20 DAYS	ALL APPROVED		
21		AMOUNTS	\$0	\$0
22	21ST THRU 100TH DAY	ALL BUT	UP TO	UP TO
23		\$114 A	\$57	\$57
24		DAY	A DAY	A DAY♦
25	101ST DAY AND AFTER	\$0	\$0	ALL COSTS
26	BLOOD			
27	FIRST 3 PINTS	\$0	50%	50%♦
28	ADDITIONAL AMOUNTS	100%	\$0	\$0
29	HOSPICE CARE			
30	AVAILABLE AS LONG AS YOUR	GENERALLY,	50% OF	50% OF
31	DOCTOR CERTIFIES YOU ARE	MOST MEDICARE	COINSUR-	COINSUR-

1	TERMINALLY ILL AND YOU	ELIGIBLE	ANCE OR	ANCE OR
2	ELECT TO RECEIVE THESE	EXPENSES FOR	COPAYMENTS	COPAYMENTS♦
3	SERVICES	OUTPATIENT		
4		DRUGS AND		
5		INPATIENT		
6		RESPIRE CARE		

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

14 PLAN K
 15 MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

16 ****ONCE YOU HAVE BEEN BILLED \$100 OF MEDICARE-APPROVED
 17 AMOUNTS FOR COVERED SERVICES (WHICH ARE NOTED WITH AN ASTERISK),
 18 YOUR PART B DEDUCTIBLE WILL HAVE BEEN MET FOR THE CALENDAR YEAR.

19	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
20	MEDICAL EXPENSES—			
21	IN OR OUT OF THE HOSPITAL			
22	AND OUTPATIENT HOSPITAL			
23	TREATMENT, SUCH AS			
24	PHYSICIAN'S SERVICES,			
25	INPATIENT AND OUTPATIENT			

1	MEDICAL AND SURGICAL			
2	SERVICES AND SUPPLIES,			
3	PHYSICAL AND SPEECH			
4	THERAPY, DIAGNOSTIC			
5	TESTS, DURABLE MEDICAL			
6	EQUIPMENT,			
7	FIRST \$100 OF MEDICARE			
8	APPROVED AMOUNTS****	\$0	\$0	\$100 (PART B
9				DEDUCTIBLE)
10				****◆
11	PREVENTIVE BENEFITS FOR	GENERALLY 75%	REMAINDER	ALL COSTS
12	MEDICARE COVERED	OR MORE OF	OF MEDI-	ABOVE MEDI-
13	SERVICES	MEDICARE AP-	CARE	CARE
14		PROVED AMOUNTS	APPROVED	APPROVED
15			AMOUNTS	AMOUNTS
16	REMAINDER OF MEDICARE	GENERALLY 80%	GENERALLY	GENERALLY
17	APPROVED AMOUNTS		10%	10%◆
18	PART B EXCESS CHARGES	\$0	\$0	ALL COSTS
19	(ABOVE MEDICARE			(AND THEY DO
20	APPROVED AMOUNTS)			NOT COUNT
21				TOWARD
22				ANNUAL OUT-
23				OF-POCKET
24				LIMIT OF
25				\$4,000)*
26	BLOOD			
27	FIRST 3 PINTS	\$0	50%	50%◆
28	NEXT \$100 OF MEDICARE			
29	APPROVED AMOUNTS****	\$0	\$0	\$100 (PART B
30				DEDUCTIBLE)
31				****◆

1	REMAINDER OF MEDICARE	GENERALLY 80%	GENERALLY	GENERALLY
2	APPROVED AMOUNTS		10%	10%♦
3	CLINICAL LABORATORY			
4	SERVICES—TESTS FOR			
5	DIAGNOSTIC SERVICES	100%	\$0	\$0

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

13 PARTS A & B

14	HOME HEALTH CARE			
15	MEDICARE APPROVED			
16	SERVICES			
17	—MEDICALLY NECESSARY			
18	SKILLED CARE SERVICES			
19	AND MEDICAL SUPPLIES	100%	\$0	\$0
20	—DURABLE MEDICAL			
21	EQUIPMENT			
22	FIRST \$100 OF MEDICARE			
23	APPROVED AMOUNTS*****	\$0	\$0	\$100 (PART B
24				DEDUCTIBLE) ♦
25	REMAINDER OF MEDICARE			
26	APPROVED AMOUNTS	80%	10%	10%♦

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

3 PLAN L

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

15 PLAN L

16 MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

17 **A BENEFIT PERIOD BEGINS ON THE FIRST DAY YOU RECEIVE
 18 SERVICE AS AN INPATIENT IN A HOSPITAL AND ENDS AFTER YOU HAVE
 19 BEEN OUT OF THE HOSPITAL AND HAVE NOT RECEIVED SKILLED CARE IN
 20 ANY OTHER FACILITY FOR 60 DAYS IN A ROW.

21	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
22	HOSPITALIZATION**			
23	SEMIPRIVATE ROOM AND			
24	BOARD, GENERAL NURSING			
25	AND MISCELLANEOUS			

1	SERVICES AND SUPPLIES			
2	FIRST 60 DAYS	ALL BUT \$912	\$684	\$228 (25% OF
3			(75% OF	PART A
4			PART A	DEDUCTIBLE) ♦
5			DEDUCTI-	
6			BLE)	
7	61ST THRU 90TH DAY	ALL BUT \$228	\$228	\$0
8		A DAY	A DAY	
9	91ST DAY AND AFTER:			
10	-WHILE USING 60			
11	LIFETIME RESERVE DAYS	ALL BUT \$456	\$456	\$0
12		A DAY	A DAY	
13	-ONCE LIFETIME RESERVE			
14	DAYS ARE USED:			
15	-ADDITIONAL 365 DAYS	\$0	100% OF	\$0***
16			MEDICARE	
17			ELIGIBLE	
18			EXPENSES	
19	-BEYOND THE			
20	ADDITIONAL 365 DAYS	\$0	\$0	ALL COSTS
21	SKILLED NURSING FACILITY			
22	CARE**			
23	YOU MUST MEET MEDICARE'S			
24	REQUIREMENTS, INCLUDING			
25	HAVING BEEN IN A HOSPITAL			
26	FOR AT LEAST 3 DAYS AND			
27	ENTERED A MEDICARE-			
28	APPROVED FACILITY WITHIN			
29	30 DAYS AFTER LEAVING THE			
30	HOSPITAL			
31	FIRST 20 DAYS	ALL APPROVED		

1		AMOUNTS	\$0	\$0
2	21ST THRU 100TH DAY	ALL BUT	UP TO	UP TO
3		\$114 A	\$85.50	\$28.50
4		DAY	A DAY	A DAY♦
5	101ST DAY AND AFTER	\$0	\$0	ALL COSTS
6	BLOOD			
7	FIRST 3 PINTS	\$0	75%	25%♦
8	ADDITIONAL AMOUNTS	100%	\$0	\$0
9	HOSPICE CARE			
10	AVAILABLE AS LONG AS YOUR	GENERALLY,	75% OF	25% OF
11	DOCTOR CERTIFIES YOU ARE	MOST MEDICARE	COINSUR-	COINSURANCE
12	TERMINALLY ILL AND YOU	ELIGIBLE	ANCE OR	OR COPAY-
13	ELECT TO RECEIVE THESE	EXPENSES FOR	COPAYMENTS	MENTS♦
14	SERVICES	OUTPATIENT		
15		DRUGS AND		
16		INPATIENT		
17		RESPIRE CARE		

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

25 PLAN L
 26 MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

27 ****ONCE YOU HAVE BEEN BILLED \$100 OF MEDICARE-APPROVED

1 AMOUNTS FOR COVERED SERVICES (WHICH ARE NOTED WITH AN ASTERISK),
 2 YOUR PART B DEDUCTIBLE WILL HAVE BEEN MET FOR THE CALENDAR YEAR.

3	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
4	MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, SUCH AS PHYSICIAN'S SERVICES, INPATIENT AND OUTPATIENT MEDICAL AND SURGICAL SERVICES AND SUPPLIES, PHYSICAL AND SPEECH THERAPY, DIAGNOSTIC TESTS, DURABLE MEDICAL EQUIPMENT, FIRST \$100 OF MEDICARE APPROVED AMOUNTS****	\$0	\$0	\$100 (PART B DEDUCTI- BLE) ****◆
20	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
25	REMAINDER OF MEDICARE APPROVED AMOUNTS	GENERALLY 80%	GENERALLY 15%	GENERALLY 5%◆
27	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) *
1			
2			
3			
4			
5	BLOOD		
6	FIRST 3 PINTS	\$0	75% 25%◆
7	NEXT \$100 OF MEDICARE		
8	APPROVED AMOUNTS****	\$0	\$0 \$100
9			(PART B
10			DEDUCTIBLE)◆
11	REMAINDER OF MEDICARE	GENERALLY	GENERALLY
12	APPROVED AMOUNTS	80%	15% 5%◆
13	CLINICAL LABORATORY		
14	SERVICES—TESTS FOR		
15	DIAGNOSTIC SERVICES	100%	\$0 \$0

16 * THIS PLAN LIMITS YOUR ANNUAL OUT-OF-POCKET PAYMENTS FOR
17 MEDICARE-APPROVED AMOUNTS TO \$2,000 PER YEAR. HOWEVER, THIS LIMIT
18 DOES NOT INCLUDE CHARGES FROM YOUR PROVIDER THAT EXCEED MEDICARE-
19 APPROVED AMOUNTS (THESE ARE CALLED "EXCESS CHARGES") AND YOU WILL
20 BE RESPONSIBLE FOR PAYING THIS DIFFERENCE IN THE AMOUNT CHARGED
21 BY YOUR PROVIDER AND THE AMOUNT PAID BY MEDICARE FOR THE ITEM OR
22 SERVICE.

23 PARTS A & B

24	HOME HEALTH CARE			
25	MEDICARE APPROVED			
26	SERVICES			
27	—MEDICALLY NECESSARY			
28	SKILLED CARE SERVICES			

1	AND MEDICAL SUPPLIES	100%	\$0	\$0
2	-DURABLE MEDICAL			
3	EQUIPMENT			
4	FIRST \$100 OF MEDI-			
5	CARE APPROVED	\$0	\$0	\$100 (PART
6	AMOUNTS			B DEDUCTI-
7				BLE) ♦
8	REMAINDER OF MEDICARE			
9	APPROVED AMOUNTS	80%	15%	5% ♦

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

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

14 (2) As used in this section:

15 (a) "Complaint" means any dissatisfaction expressed by an
16 individual concerning a medicare select insurer or its network
17 providers.

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

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

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

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

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

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

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

14 (4) The commissioner may authorize an insurer to offer a
15 medicare select policy or certificate, pursuant to this section
16 and section 1882 of part C of title XVIII of the social security
17 act, ~~chapter 531, 49 Stat. 620, 42 U.S.C.~~ **USC** 1395ss, if the
18 commissioner finds that the insurer has satisfied all necessary
19 requirements.

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

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

27 (a) Evidence that all covered services that are subject to

1 restricted network provisions are available and accessible
2 through network providers, as follows:

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

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

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

16 (iv) That emergency care is available 24 hours per day and 7
17 days per week.

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

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

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

2 (d) A description of the quality assurance program,

3 including all of the following:

4 (i) The formal organizational structure.

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

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

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

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

14 (g) Any other information requested by the commissioner.

15 (7) A medicare select insurer shall file any proposed
16 changes to the plan of operation, except for changes to the list
17 of network providers, with the commissioner prior to implementing
18 any changes. An updated list of network providers shall be filed
19 with the commissioner at least quarterly. Changes shall be
20 considered approved by the commissioner after 30 days unless
21 specifically disapproved.

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

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

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

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

15 (b) A description, including address, phone number, and
16 hours of operation, of the network providers, including primary
17 care physicians, specialty physicians, hospitals, and other
18 providers.

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

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

27 (e) A description of limitations on referrals to restricted

1 network providers and to other providers.

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

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

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

13 (12) A medicare select insurer shall have and use procedures
14 for hearing complaints and resolving written grievances from
15 subscribers. The procedures shall be aimed at mutual agreement
16 for settlement and may include arbitration procedures. The
17 grievance procedure shall be described in the policy and
18 certificate and in the outline of coverage. At the time the
19 policy or certificate is issued, the insurer shall provide
20 detailed information to the policyholder describing how a
21 grievance may be registered with the insurer. Grievances shall be
22 considered in a timely manner and shall be transmitted to
23 appropriate decision-makers who have authority to fully
24 investigate the issue and take corrective action. If a grievance
25 is found to be valid, corrective action shall be taken promptly.
26 All concerned parties shall be notified about the results of a
27 grievance. The insurer shall report no later than each March 31

1 to the commissioner regarding its grievance procedure. The report
2 shall be in a format prescribed by the commissioner and shall
3 contain the number of grievances filed in the past year and a
4 summary of the subject, nature, and resolution of those
5 grievances.

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

11 (14) At the request of an individual insured under a
12 medicare select policy or certificate, a medicare select insurer
13 shall make available to the individual insured the opportunity to
14 purchase a medicare supplement policy or certificate offered by
15 the insurer that has comparable or lesser benefits and that does
16 not contain a restricted network provision. The insurer shall
17 make the policies or certificates available without requiring
18 evidence of insurability after the medicare supplement policy or
19 certificate has been in force for 6 months. For the purposes of
20 this subsection, a medicare supplement policy or certificate
21 shall be considered to have comparable or lesser benefits unless
22 it contains 1 or more significant benefits not included in the
23 medicare select policy or certificate being replaced. For the
24 purposes of this subsection, a significant benefit means coverage
25 for the medicare part A deductible, ~~coverage for outpatient~~
26 ~~prescription drugs,~~ coverage for at-home recovery services, or
27 coverage for part B excess charges.

1 (15) Medicare select policies and certificates shall provide
2 for continuation of coverage if the secretary of health and human
3 services determines that medicare select policies and
4 certificates issued pursuant to this section should be
5 discontinued due to either the failure of the medicare select
6 program to be reauthorized under law or its substantial
7 amendment. Each medicare select insurer shall make available to
8 each individual insured under a medicare select policy or
9 certificate the opportunity to purchase any medicare supplement
10 policy or certificate offered by the insurer that has comparable
11 or lesser benefits and that does not contain a restricted network
12 provision. The issuer shall make the policies and certificates
13 available without requiring evidence of insurability. For the
14 purposes of this subsection, a medicare supplement policy or
15 certificate will be considered to have comparable or lesser
16 benefits unless it contains 1 or more significant benefits not
17 included in the medicare select policy or certificate being
18 replaced. For the purposes of this subsection, a significant
19 benefit means coverage for the medicare part A deductible,
20 ~~coverage for prescription drugs,~~ coverage for at-home recovery
21 service, or coverage for part B excess charges.

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

26 Sec. 3819. (1) An insurance policy shall not be titled,
27 advertised, solicited, or issued for delivery in this state as a

1 medicare supplement policy if the policy does not meet the
2 minimum standards prescribed in this section. These minimum
3 standards are in addition to all other requirements of this
4 chapter.

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

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

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

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

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

26 (e) Termination of a medicare supplement policy shall not
27 reduce or limit the payment of benefits for any continuous loss

1 that commenced while the policy was in force, but the extension
2 of benefits beyond the period during which the policy was in
3 force may be predicated upon the continuous total disability of
4 the insured, limited to the duration of the policy benefit
5 period, if any, or payment of the maximum benefits. **RECEIPT OF**
6 **MEDICARE PART D BENEFITS WILL NOT BE CONSIDERED IN DETERMINING A**
7 **CONTINUOUS LOSS.**

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

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

17 (3) A medicare supplement policy shall provide that benefits
18 and premiums under the policy shall be suspended at the request
19 of the policyholder or certificate holder for a period not to
20 exceed 24 months in which the policyholder or certificate holder
21 has applied for and is determined to be entitled to medical
22 assistance under medicaid, but only if the policyholder or
23 certificate holder notifies the insurer of such assistance within
24 90 days after the date the individual becomes entitled to the
25 assistance. Upon receipt of timely notice, the insurer shall
26 return to the policyholder or certificate holder that portion of
27 the premium attributable to the period of medicaid eligibility,

1 subject to adjustment for paid claims. If a suspension occurs and
2 if the policyholder or certificate holder loses entitlement to
3 medical assistance under medicaid, the policy shall be
4 automatically reinstated effective as of the date of
5 termination of the assistance if the policyholder or certificate
6 holder provides notice of loss of medicaid medical assistance
7 within 90 days after the date of the loss and pays the premium
8 attributable to the period effective as of the date of
9 termination of the assistance. Each medicare supplement policy
10 shall provide that benefits and premiums under the policy shall
11 be suspended at the request of the policyholder if the
12 policyholder is entitled to benefits under section 226(b) of
13 title II of the social security act, and is covered under a group
14 health plan as defined in section 1862(b)(1)(A)(v) of the social
15 security act. If suspension occurs and if the policyholder or
16 certificate holder loses coverage under the group health plan,
17 the policy shall be automatically reinstated effective as of
18 the date of loss of coverage if the policyholder provides notice
19 of loss of coverage within 90 days after the date of the loss and
20 pays the premium attributable to the period, effective as of the
21 date of termination of enrollment in the group health plan. All
22 of the following apply to the reinstatement of a medicare
23 supplement policy under this subsection:

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

26 (b) Reinstated coverage shall be substantially equivalent
27 to coverage in effect before the date of the suspension. **IF THE**

1 SUSPENDED MEDICARE SUPPLEMENT POLICY PROVIDED COVERAGE FOR
2 OUTPATIENT PRESCRIPTION DRUGS, REINSTITUTION OF THE POLICY FOR
3 MEDICARE PART D ENROLLEES SHALL BE WITHOUT COVERAGE FOR
4 OUTPATIENT PRESCRIPTION DRUGS AND SHALL OTHERWISE PROVIDE
5 SUBSTANTIALLY EQUIVALENT COVERAGE TO THE COVERAGE IN EFFECT
6 BEFORE THE DATE OF THE SUSPENSION.

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

12 Sec. 3823. (1) An insurance policy shall not be titled,
13 advertised, solicited, or issued for delivery in this state as a
14 medicare supplement policy unless the definitions and terms
15 contained in the policy are such that covered benefits under the
16 policy are not more restrictive than covered benefits under
17 medicare and those required to be provided under state law.

18 (2) A MEDICARE SUPPLEMENT POLICY WITH BENEFITS FOR
19 OUTPATIENT PRESCRIPTION DRUGS IN EXISTENCE PRIOR TO JANUARY 1,
20 2006 SHALL BE RENEWED FOR CURRENT POLICYHOLDERS WHO DO NOT ENROLL
21 IN PART D AT THE OPTION OF THE POLICYHOLDER.

22 (3) A MEDICARE SUPPLEMENT POLICY WITH BENEFITS FOR
23 OUTPATIENT PRESCRIPTION DRUGS SHALL NOT BE ISSUED AFTER DECEMBER
24 31, 2005.

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

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

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

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

12 (2) Application forms or a supplementary application or
13 other form to be signed by the applicant and agent for medicare
14 supplement policies shall include the following statements and
15 questions designed to inform and elicit information as to
16 whether, as of the date of the application, the applicant
17 **CURRENTLY** has ~~another~~ medicare supplement, **MEDICARE ADVANTAGE**,
18 **MEDICAID COVERAGE**, or ~~other~~ **ANOTHER** health insurance policy or
19 certificate in force or whether a medicare supplement policy or
20 certificate is intended to replace any disability or other health
21 policy or certificate presently in force:

22 [STATEMENTS]

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

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

26 (3) ~~The~~ **IF, AFTER PURCHASING THIS POLICY, YOU BECOME**
27 **ELIGIBLE FOR MEDICAID, THE** benefits and premiums under your

1 medicare supplement policy will be suspended during your
2 entitlement to benefits under medicaid for 24 months. You must
3 request this suspension within 90 days of becoming eligible for
4 medicaid. If you are no longer entitled to medicaid, your policy
5 will be reinstated if requested within 90 days of losing
6 medicaid eligibility. IF THE MEDICARE SUPPLEMENT PROVIDED
7 COVERAGE FOR OUTPATIENT PRESCRIPTION DRUGS AND YOU ENROLLED IN
8 MEDICARE PART D WHILE YOUR POLICY WAS SUSPENDED, THE REINSTITUTED
9 POLICY WILL NOT HAVE OUTPATIENT PRESCRIPTION DRUG COVERAGE, BUT
10 WILL OTHERWISE BE SUBSTANTIALLY EQUIVALENT TO YOUR COVERAGE
11 BEFORE THE DATE OF THE SUSPENSION.

12 (4) IF YOU ARE ELIGIBLE FOR, AND HAVE ENROLLED IN, A
13 MEDICARE SUPPLEMENT POLICY BY REASON OF DISABILITY AND YOU LATER
14 BECOME COVERED BY AN EMPLOYER OR UNION-BASED GROUP HEALTH PLAN,
15 THE BENEFITS AND PREMIUMS UNDER YOUR MEDICARE SUPPLEMENT POLICY
16 CAN BE SUSPENDED, IF REQUESTED, WHILE YOU ARE COVERED UNDER THE
17 EMPLOYER OR UNION-BASED GROUP HEALTH PLAN. IF YOU SUSPEND YOUR
18 MEDICARE SUPPLEMENT POLICY UNDER THESE CIRCUMSTANCES, AND LATER
19 LOSE YOUR EMPLOYER OR UNION-BASED GROUP HEALTH PLAN, YOUR
20 SUSPENDED MEDICARE SUPPLEMENT POLICY, OR IF THAT IS NO LONGER
21 AVAILABLE, A SUBSTANTIALLY EQUIVALENT POLICY, WILL BE
22 REINSTITUTED IF REQUESTED WITHIN 90 DAYS OF LOSING YOUR EMPLOYER
23 OR UNION-BASED GROUP HEALTH PLAN. IF THE MEDICARE SUPPLEMENT
24 POLICY PROVIDED COVERAGE FOR OUTPATIENT PRESCRIPTION DRUGS AND
25 YOU ENROLLED IN MEDICARE PART D WHILE YOUR POLICY WAS SUSPENDED,
26 THE REINSTITUTED POLICY WILL NOT HAVE OUTPATIENT PRESCRIPTION
27 DRUG COVERAGE, BUT WILL OTHERWISE BE SUBSTANTIALLY EQUIVALENT TO

1 TO THE BEST OF YOUR KNOWLEDGE,

2

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

4 YES ____ NO ____

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

7 YES ____ NO ____

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

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

11 [NOTE TO APPLICANT: IF YOU ARE PARTICIPATING IN A
12 "SPEND-DOWN PROGRAM" AND HAVE NOT MET YOUR "SHARE
13 OF COST," PLEASE ANSWER NO TO THIS QUESTION.]

14 YES ____ NO ____

15 IF YES,

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

18 YES ____ NO ____

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

21 YES ____ NO ____

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

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

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

1 YES ____ NO ____

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

4 YES ____ NO ____

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

7 YES ____ NO ____

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

10 YES ____ NO ____

11 (B) IF SO, WITH WHAT COMPANY, AND WHAT PLAN DO YOU
12 HAVE [OPTIONAL FOR DIRECT MAILERS]?

13 _____

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

16 YES ____ NO ____

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

20 YES ____ NO ____

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

22 _____

23 _____

24 _____

25 _____

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

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

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

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

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

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

25 **"NOTICE TO APPLICANT REGARDING REPLACEMENT**
26 **OF MEDICARE SUPPLEMENT COVERAGE**
27 **(INSURANCE COMPANY'S NAME AND ADDRESS)**

1 **SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.**

2 According to (your application) (information you have
3 furnished), you intend to drop or otherwise terminate existing
4 medicare supplement coverage **OR MEDICARE ADVANTAGE PLAN** and
5 replace it with a policy or certificate to be issued by (company
6 name) insurance company. Your new policy or certificate provides
7 30 days within which you may decide without cost whether you
8 desire to keep the policy or certificate.

9 You should review this new coverage carefully comparing it
10 with all disability and other health coverage you now have and
11 terminate your present coverage only if, after due consideration,
12 you find that purchase of this medicare supplement coverage is a
13 wise decision.

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

16 (Use additional sheets as necessary.)

17 I have reviewed your current medical or health coverage. The
18 replacement of coverage involved in this transaction does not
19 duplicate coverage, to the best of my knowledge. The replacement
20 policy is being purchased for the following reasons (check 1):

21 _____ Additional benefits

22 _____ No change in benefits, but lower premiums

23 _____ Fewer benefits and lower premiums

24 _____ **MY PLAN HAS OUTPATIENT PRESCRIPTION DRUG COVERAGE AND**

25 **I AM ENROLLING IN PART D**

26 _____ **DISENROLLMENT FROM A MEDICARE ADVANTAGE PLAN. PLEASE**

1 **EXPLAIN REASON FOR DISENROLLMENT. [OPTIONAL ONLY FOR DIRECT**
2 **MAILERS.]**

3 _____ Other. (Please specify)

4 1. Health conditions which you may presently have (pre-
5 existing conditions) may not be immediately or fully covered
6 under the new policy. This could result in denial or delay of a
7 claim for benefits under the new policy, whereas a similar claim
8 might have been payable under your present policy. This paragraph
9 may be deleted by an insurer if the replacement does not involve
10 application of a new pre-existing condition limitation.

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

18 3. If, after thinking about it carefully, you still wish to
19 drop your present coverage and replace it with new coverage, be
20 certain to truthfully and completely answer all questions on the
21 application concerning your medical and health history. Failure
22 to include all material medical information on an application may
23 provide a basis for the insurer to deny any future claims and to
24 refund your premium as though your policy or certificate had
25 never been in force. After the application has been completed,
26 and before you sign it, review it carefully to be certain that
27 all information has been properly recorded. (If the policy or

1 certificate is guaranteed issue, this paragraph need not appear.)
2 4. Do not cancel your present policy until you have received
3 your new policy and are sure that you want to keep it.

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

7 _____
8 Typed Name and Address of Agent or Broker

9 _____
10 (Date)

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

12 _____
13 (Date)

14 _____
15 (Applicant's Signature)

16 _____
17 (Applicant's Printed Name)

18 _____
19 (Applicant's Address)

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

21 Sec. 3830. (1) An eligible person is an individual described
22 in subsection (2) who applies to enroll under a medicare
23 supplement policy during the period described in subsection (3),
24 and who submits evidence of the date of termination or
25 disenrollment **OR MEDICARE PART D ENROLLMENT** with the application
26 for a medicare supplement policy. For an eligible person, an
27 insurer shall not deny or condition the issuance or effectiveness
28 of a medicare supplement policy described in subsections (5),
29 (6), and (7) that is offered and is available for issuance to new

1 enrollees by the insurer, shall not discriminate in the pricing
2 of the medicare supplement policy because of health status,
3 claims experience, receipt of health care, or medical condition,
4 and shall not impose an exclusion of benefits based on a
5 preexisting condition under the medicare supplement policy.

6 (2) An eligible person under this section is an individual
7 that meets any of the following:

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

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

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

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

26 (iii) The individual is no longer eligible to elect the plan
27 because of a change in the individual's place of residence or

1 other change in circumstances specified by the secretary, but not
2 including termination of the individual's enrollment on the basis
3 described in section 1851(g)(3)(b) of the social security act,
4 where the individual has not paid premiums on a timely basis or
5 has engaged in disruptive behavior as specified in standards
6 established under section 1856 of the social security act, or the
7 plan is terminated for all individuals within a residence area.

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

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

21 (c) Is enrolled with an eligible organization under a
22 contract under section 1876 of the social security act, a similar
23 organization operating under demonstration project authority,
24 effective for periods before April 1, 1999, an organization under
25 an agreement under section 1833(a)(1)(A) of the social security
26 act, health care prepayment plan, or an organization under a
27 medicare select policy, and the enrollment ceases under the same

1 circumstances that would permit discontinuance of an individual's
2 election of coverage under subdivision (b).

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

5 (i) The insolvency of the insurer or bankruptcy of the
6 noninsurer organization or of other involuntary termination of
7 coverage or enrollment under the policy.

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

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

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

26 (f) Upon first becoming eligible for benefits under part A
27 of medicare at age 65, enrolls in a ~~medicare+choice~~ **MEDICARE**

1 **ADVANTAGE** plan under part C of medicare, or with a PACE provider
2 under section 1894 of the social security act, and disenrolls
3 from the plan or program by not later than 12 months after the
4 effective date of enrollment.

5 (G) **ENROLLS IN A MEDICARE PART D PLAN DURING THE INITIAL**
6 **ENROLLMENT PERIOD AND, AT THE TIME OF ENROLLMENT IN PART D, WAS**
7 **ENROLLED UNDER A MEDICARE SUPPLEMENT POLICY THAT COVERS**
8 **OUTPATIENT PRESCRIPTION DRUGS AND THE INDIVIDUAL TERMINATES**
9 **ENROLLMENT IN THE MEDICARE SUPPLEMENT POLICY AND SUBMITS EVIDENCE**
10 **OF ENROLLMENT IN MEDICARE PART D ALONG WITH THE APPLICATION FOR A**
11 **POLICY DESCRIBED IN SUBSECTION (5).**

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

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

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

27 (c) For an individual described in subsection (2)(d)(i), the

1 guaranteed issue time period begins on the earlier of the date
2 that the individual receives a notice of termination, a notice of
3 the issuer's bankruptcy or insolvency, or other such similar
4 notice, if any, or the date that the applicable coverage is
5 terminated, and ends on the date that is 63 days after the date
6 the coverage is terminated.

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

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

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

24 (4) For an individual described in subsection (2)(e) whose
25 enrollment with an organization or provider described in
26 subsection (2)(e) is involuntarily terminated within the first 12
27 months of enrollment, and who, without an intervening enrollment,

1 enrolls with another such organization or provider, the
 2 subsequent enrollment shall be considered an initial enrollment
 3 described in subsection (2)(e). For an individual described in
 4 subsection (2)(f) whose enrollment within a plan or in a program
 5 described in subsection (2)(f) is involuntarily terminated within
 6 the first 12 months of enrollment, and who, without an
 7 intervening enrollment, enrolls in another such plan or program,
 8 the subsequent enrollment shall be considered an initial
 9 enrollment described in subsection (2)(f). For purposes of
 10 subsections (2)(e) and (f), an enrollment of an individual with
 11 an organization or provider described in subsection (2)(e), or
 12 with a plan or provider described in subsection (2)(f), shall not
 13 be considered to be an initial enrollment after the 2-year period
 14 beginning on the date on which the individual first enrolled with
 15 such an organization, provider, or plan.

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

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

27 (B) **AT THE ELECTION OF THE POLICYHOLDER, AN A, B, C, F,**

1 INCLUDING F WITH A HIGH DEDUCTIBLE, K, OR L POLICY THAT IS
2 OFFERED BY AN INSURER.

3 (6) The medicare supplement policy to which an eligible
4 person is entitled under subsection (2)(e) is the same medicare
5 supplement policy in which the individual was most recently
6 previously enrolled, if available from the same insurer, or, if
7 not so available, a policy described in subsection (5).

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

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

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

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

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

24 (c) Inquire and otherwise make every reasonable effort to
25 identify whether a prospective applicant for medicare supplement
26 insurance already has disability or other health coverage and the
27 types and amounts of coverage.

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

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

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

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

14 (5) ~~(4)~~ A medical supplement policy shall display
15 prominently by type, stamp, or other appropriate means, on the
16 first page of the policy the following: "Notice to buyer: This
17 policy may not cover all of your medical expenses.".

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

26 (2) If a medicare supplement policy is terminated by the
27 group policyholder and is not replaced as provided under

1 subsection (4), the issuer shall offer certificate holders an
2 individual medicare supplement policy that at the option of the
3 certificate holder provides for continuation of the benefits
4 contained in the group policy or provides for such benefits as
5 otherwise meet the requirements of section 3819.

6 (3) If an individual is a certificate holder in a group
7 medicare supplement policy and the individual terminates
8 membership in the group, the issuer shall offer the certificate
9 holder the conversion opportunity described in subsection (4) or
10 at the option of the group policyholder, offer the certificate
11 holder continuation of coverage under the group policy.

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

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

25 Sec. 3841. (1) Except for riders or endorsements by which
26 the insurer effectuates a request made in writing by the insured,
27 exercises a specifically reserved right under a medicare

1 supplement policy, or as required to reduce or eliminate benefits
2 to avoid duplication of medicare benefits, all riders or
3 endorsements added to a medicare supplement policy after date of
4 issue or at reinstatement or renewal that reduce or eliminate
5 benefits or coverage in the policy shall require signed
6 acceptance by the insured. After the date of policy issue, any
7 rider or endorsement that increases benefits or coverage with a
8 concomitant increase in premium during the policy term shall be
9 agreed to in writing and signed by the insured, unless the
10 benefits are required minimum standards for medicare supplement
11 policies or if the increase in benefits or coverage is required
12 by law. If a separate additional premium is charged for benefits
13 provided in connection with riders or endorsements, the premium
14 charged shall be set forth in the policy.

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

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

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

26 (5) As soon as practicable but prior to the effective date
27 of any changes in medicare benefits, every insurer offering

1 medicare supplement insurance policies in this state shall file
2 with the commissioner both of the following:

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

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

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

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

1 solicitation, and shall include both of the following:

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

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

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

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

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

21 **(3) —(2)—** An insurer shall not use or change premium rates
22 for a medicare supplement policy unless the rates, rating
23 schedule, and supporting documentation have been filed with and
24 approved by the commissioner in accordance with the filing
25 requirements and procedures prescribed by the commissioner.

26 **(4) —(3)—** Except as provided in subsection **—(4)— (5),** an
27 insurer shall not file for approval more than 1 form of a policy

1 or certificate for each individual policy and group policy
2 standard medicare supplement benefit plan.

3 (5) ~~—(4)—~~ With the approval of the commissioner, an issuer
4 may offer up to 4 additional policy forms or certificate forms of
5 the same type for the same standard medicare supplement benefit
6 plan, 1 for each of the following cases:

7 (a) The inclusion of new or innovative benefits.

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

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

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

14 (6) ~~—(5)—~~ Except as provided in subsection ~~—(6)—~~ (7), an
15 insurer shall continue to make available for purchase any
16 medicare supplement policy form or certificate form issued after
17 the effective date of this chapter that has been approved by the
18 commissioner. A medicare supplement policy form or certificate
19 form shall not be considered to be available for purchase unless
20 the insurer has actively offered it for sale in the previous 12
21 months.

22 (7) ~~—(6)—~~ An insurer may discontinue the availability of a
23 medicare supplement policy form or certificate form if the
24 insurer provides to the commissioner in writing its decision to
25 discontinue at least 30 days prior to discontinuing the
26 availability of the form of the medicare supplement policy. After
27 receipt of the notice by the commissioner, the insurer shall no

1 longer offer for sale the medicare supplement policy form or
2 certificate form in this state.

3 (8) ~~—(7)—~~ An insurer that discontinues the availability of a
4 medicare supplement policy form or certificate form pursuant to
5 subsection ~~—(6)—~~ (7) shall not file for approval a new medicare
6 supplement policy form or certificate form of the same type for
7 the same standard medicare supplement benefit plan as the
8 discontinued form for a period of 5 years after the insurer
9 provides notice to the commissioner of the discontinuance. The
10 period of discontinuance may be reduced if the commissioner
11 determines that a shorter period is appropriate.

12 (9) ~~—(8)—~~ The sale or other transfer of medicare supplement
13 business to another insurer shall be considered a discontinuance
14 for the purposes of this section. In addition, a change in the
15 rating structure or methodology shall be considered a
16 discontinuance under this section unless the insurer complies
17 with the following requirements:

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

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

1 (10) ~~—(9)—~~ The experience of all medicare supplement policy
2 forms or certificate forms of the same type in a standard
3 medicare supplement benefit plan shall be combined for purposes
4 of the refund or credit calculation prescribed in section 3853
5 except that forms assumed under an assumption reinsurance
6 agreement shall not be combined with the experience of other
7 forms for purposes of the refund or credit calculation.

8 (11) ~~—(10)—~~ Each insurer that issues medicare supplement
9 policies for delivery in this state shall comply with sections
10 1842 and 1882 of title XVIII of the social security act, ~~chapter~~
11 ~~531, 49 Stat. 620, 42 U.S.C. USC~~ 1395u and 1395ss, and shall
12 certify that compliance on the medicare supplement insurance
13 experience reporting form.

14 (12) ~~—(11)—~~ For the purposes of this section, "type" means
15 an individual policy, a group policy, an individual medicare
16 select policy, or a group medicare select policy.

17 Enacting section 1. Sections 451 to 499a of the nonprofit
18 health care corporation reform act, 1980 PA 350, MCL 550.1451 to
19 550.1499a, are repealed.