SENATE BILL No. 743

August 19, 2009, Introduced by Senator SANBORN and referred to the Committee on Economic Development and Regulatory Reform.

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending sections 3801, 3803, 3807, 3809, 3811, 3815, 3819, 3831, and 3839 (MCL 500.3801, 500.3803, 500.3807, 500.3809, 500.3811, 500.3815, 500.3819, 500.3831, and 500.3839), sections 3801, 3807, 3809, 3811, 3815, 3819, 3831, and 3839 as amended by 2006 PA 462 and section 3803 as added by 1992 PA 84, and by adding sections 3807a, 3809a, 3811a, and 3819a.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 3801. As used in this chapter:

(a) "Applicant" means:

(*i*) For an individual medicare supplement policy, the person who seeks to contract for benefits.

(*ii*) For a group medicare supplement policy or certificate,

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the proposed certificate holder.

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

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

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

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

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

(*i*) A group health plan.

(*ii*) Health insurance coverage.

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

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

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

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

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

(*viii*) A health plan offered under chapter 89 of title 5 of

the United States Code, 5 USC 8901 to 8914.

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

(*x*) Health care under section 5(e) of title I of the peace corps act, 22 USC 2504.

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

(h) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in section 3 of subtitle A of title I of the employee retirement income security act of 1974, 29 USC 1002.

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

(j) "Insurer" includes any entity, including a health care corporation operating pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704, delivering or issuing for delivery in this state medicare supplement policies.

(k) "Medicaid" means title XIX of the social security act, 42 USC 1396 to 1396v.

(*l*) "Medicare" means title XVIII of the social security act, 42 USC 1395 to 1395ggg.

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

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

(*ii*) Medical savings account plans coupled with a contribution into a medicare advantage medical savings account.

(*iii*) Medicare advantage private fee-for-service plans.

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

(o) "Medicare supplement policy" means an individual, nongroup, or group policy or certificate that is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare and medicare select policies and certificates under section 3817. Medicare supplement policy does not include a policy, certificate, or contract of 1 or more employers or labor organizations, or of the trustees of a fund established by 1 or more employers or labor organizations, or both, for employees or former employees, or both, or for members

or former members, or both, of the labor organizations. Medicare supplement policy does not include medicare advantage plans established under medicare part C, outpatient prescription drug plans established under medicare part D, or any health care prepayment plan that provides benefits pursuant to an agreement under section 1833(a)(1)(A) of the social security act.

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

(Q) "PRESTANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN", "PRESTANDARDIZED BENEFIT PLAN", OR "PRESTANDARDIZED PLAN" MEANS A GROUP OR INDIVIDUAL POLICY OF MEDICARE SUPPLEMENT INSURANCE ISSUED PRIOR TO JUNE 2, 1992.

(R) "1990 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN", "1990 STANDARDIZED BENEFIT PLAN", OR "1990 PLAN" MEANS A GROUP OR INDIVIDUAL POLICY OF MEDICARE SUPPLEMENT INSURANCE ISSUED ON OR AFTER JUNE 2, 1992 WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010 AND INCLUDES MEDICARE SUPPLEMENT INSURANCE POLICIES AND CERTIFICATES RENEWED ON OR AFTER THAT DATE WHICH ARE NOT REPLACED BY THE ISSUER AT THE REQUEST OF THE INSURED.

(S) "2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN", "2010 STANDARDIZED BENEFIT PLAN", OR "2010 PLAN" MEANS A GROUP OR INDIVIDUAL POLICY OF MEDICARE SUPPLEMENT INSURANCE WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010.

(T) ~~(q)~~ "Policy form" means the form on which the policy or certificate is delivered or issued for delivery by the insurer.

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

(V) ~~(s)~~ "Social security act" means the social security act, 42 USC 301 to 1397jj.

Sec. 3803. (1) Except as provided in subsection (2), this chapter applies to a medicare supplement policy delivered, issued for delivery, or renewed in this state **WITH AN EFFECTIVE DATE** on or after ~~the effective date of this chapter~~ **JUNE 2, 1992**.

(2) ~~Sections~~ **EXCEPT FOR SECTIONS 3807A,** 3809, 3811, ~~and 3819(1) do not apply~~ **3819(1) AND (4), AND 3819A, THIS CHAPTER APPLIES** to a medicare supplement policy issued before ~~the effective date of this chapter~~ **JUNE 2, 1992**.

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

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

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

(c) Upon exhaustion of the medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100% of

the medicare part A eligible expenses for hospitalization paid at the applicable prospective payment system rate or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

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

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

(2) Standards for plans K and L are as follows:

(a) Standardized medicare supplement benefit plan K shall consist of the following:

(*i*) Coverage of 100% of the part A hospital coinsurance amount for each day used from the sixty-first day through the ninetieth day in any medicare benefit period.

(*ii*) Coverage of 100% of the part A hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the ninety-first day through the one hundred fiftieth day in any medicare benefit period.

(*iii*) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the medicare part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other

appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the insurer's payment as payment in full and may not bill the insured for any balance.

(*iv*) Medicare part A deductible: coverage for 50% of the medicare part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*v*) Skilled nursing facility care: coverage for 50% of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare part A until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*vi*) Hospice care: coverage for 50% of cost sharing for all part A medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*vii*) Coverage for 50%, under medicare part A or B, of the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*viii*) Except for coverage provided in subparagraph (*ix*) below, coverage for 50% of the cost sharing otherwise applicable under medicare part B after the policyholder pays the part B deductible until the out-of-pocket limitation is met as described in

subparagraph (*x*).

(*ix*) Coverage of 100% of the cost sharing for medicare part B preventive services after the policyholder pays the part B deductible.

(*x*) Coverage of 100% of all cost sharing under medicare parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under medicare parts A and B of $4,000.00 in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the United States department of health and human services.

(b) Standardized medicare supplement benefit plan L shall consist of the following:

(*i*) The benefits described in subdivision (a)(*i*), (*ii*), (*iii*), and (*ix*).

(*ii*) The benefit described in subdivision (a)(*iv*), (*v*), (*vi*), (*vii*), and (*viii*), but substituting 75% for 50%.

(*iii*) The benefit described in subdivision (a)(*x*), but substituting $2,000.00 for $4,000.00.

(3) THIS SECTION APPLIES TO MEDICARE SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010.

SEC. 3807A. (1) THIS SECTION APPLIES TO ALL MEDICARE SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010.

(2) EVERY INSURER ISSUING A MEDICARE SUPPLEMENT INSURANCE

POLICY IN THIS STATE SHALL MAKE AVAILABLE A MEDICARE SUPPLEMENT INSURANCE POLICY THAT INCLUDES A BASIC CORE PACKAGE OF BENEFITS TO EACH PROSPECTIVE INSURED. AN INSURER ISSUING A MEDICARE SUPPLEMENT INSURANCE POLICY IN THIS STATE MAY MAKE AVAILABLE TO PROSPECTIVE INSUREDS BENEFITS PURSUANT TO SECTION 3809A THAT ARE IN ADDITION TO, BUT NOT INSTEAD OF, THE BASIC CORE PACKAGE. THE BASIC CORE PACKAGE OF BENEFITS SHALL INCLUDE ALL OF THE FOLLOWING:

(A) COVERAGE OF PART A MEDICARE ELIGIBLE EXPENSES FOR HOSPITALIZATION TO THE EXTENT NOT COVERED BY MEDICARE FROM THE SIXTY-FIRST DAY THROUGH THE NINETIETH DAY IN ANY MEDICARE BENEFIT PERIOD.

(B) COVERAGE OF PART A MEDICARE ELIGIBLE EXPENSES INCURRED FOR HOSPITALIZATION TO THE EXTENT NOT COVERED BY MEDICARE FOR EACH MEDICARE LIFETIME INPATIENT RESERVE DAY USED.

(C) UPON EXHAUSTION OF THE MEDICARE HOSPITAL INPATIENT COVERAGE INCLUDING THE LIFETIME RESERVE DAYS, COVERAGE OF 100% OF THE MEDICARE PART A ELIGIBLE EXPENSES FOR HOSPITALIZATION PAID AT THE APPLICABLE PROSPECTIVE PAYMENT SYSTEM RATE OR OTHER APPROPRIATE MEDICARE STANDARD OF PAYMENT, SUBJECT TO A LIFETIME MAXIMUM BENEFIT OF AN ADDITIONAL 365 DAYS.

(D) COVERAGE UNDER MEDICARE PARTS A AND B FOR THE REASONABLE COST OF THE FIRST 3 PINTS OF BLOOD OR EQUIVALENT QUANTITIES OF PACKED RED BLOOD CELLS, AS DEFINED UNDER FEDERAL REGULATIONS UNLESS REPLACED IN ACCORDANCE WITH FEDERAL REGULATIONS.

(E) COVERAGE FOR THE COINSURANCE AMOUNT, OR THE COPAYMENT AMOUNT PAID FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES UNDER A

PROSPECTIVE PAYMENT SYSTEM, OF MEDICARE ELIGIBLE EXPENSES UNDER PART B REGARDLESS OF HOSPITAL CONFINEMENT, SUBJECT TO THE MEDICARE PART B DEDUCTIBLE.

(F) COVERAGE OF COST SHARING FOR ALL PART A MEDICARE ELIGIBLE HOSPICE CARE AND RESPITE CARE EXPENSES.

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

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

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

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

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

(e) One hundred percent of the medicare part B excess charges: coverage for all of the difference between the actual

medicare part B charge as billed, not to exceed any charge limitation established by medicare or state law, and the medicare-approved part B charge.

(f) Basic outpatient prescription drug benefit: coverage for 50% of outpatient prescription drug charges, after a $250.00 calendar year deductible, to a maximum of $1,250.00 in benefits received by the insured per calendar year, to the extent not covered by medicare. The outpatient prescription drug benefit may be included for sale or issuance in a medicare supplement policy until January 1, 2006.

(g) Extended outpatient prescription drug benefit: coverage for 50% of outpatient prescription drug charges, after a $250.00 calendar year deductible, to a maximum of $3,000.00 in benefits received by the insured per calendar year, to the extent not covered by medicare. The outpatient prescription drug benefit may be included for sale or issuance in a medicare supplement policy until January 1, 2006.

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

because of an injury or an illness of sudden and unexpected onset.

(i) Preventive medical care benefit: Coverage for the following preventive health services not covered by medicare:

(*i*) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (*ii*) and patient education to address preventive health care measures.

(*ii*) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

(j) At-home recovery benefit: coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery. At-home recovery services provided shall be primarily services that assist in activities of daily living. The insured's attending physician shall certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by medicare. Coverage is excluded for home care visits paid for by medicare or other government programs and care provided by family members, unpaid volunteers, or providers who are not care providers. Coverage is limited to:

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

medicare approved home care plan of treatment.

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

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

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

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

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

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

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

(k) New or innovative benefits: an insurer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

(2) Reimbursement for the preventive screening tests and

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

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

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

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

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

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

(4) THIS SECTION APPLIES TO MEDICARE SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR ISSUED FOR DELIVERY ON OR AFTER JUNE 2, 1992 WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010.

SEC. 3809A. (1) THIS SECTION APPLIES TO ALL MEDICARE SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010.

(2) IN ADDITION TO THE BASIC CORE PACKAGE OF BENEFITS REQUIRED UNDER SECTION 3807A, THE FOLLOWING BENEFITS MAY BE INCLUDED IN A MEDICARE SUPPLEMENT INSURANCE POLICY AND IF INCLUDED SHALL CONFORM TO SECTION 3811A(6)(B) TO (J):

(A) MEDICARE PART A DEDUCTIBLE: COVERAGE FOR 100% OF THE MEDICARE PART A INPATIENT HOSPITAL DEDUCTIBLE AMOUNT PER BENEFIT PERIOD.

(B) MEDICARE PART A DEDUCTIBLE: COVERAGE FOR 50% OF THE MEDICARE PART A INPATIENT HOSPITAL DEDUCTIBLE AMOUNT PER BENEFIT PERIOD.

(C) SKILLED NURSING FACILITY CARE: COVERAGE FOR THE ACTUAL BILLED CHARGES UP TO THE COINSURANCE AMOUNT FROM THE TWENTY-FIRST DAY THROUGH THE ONE HUNDREDTH DAY IN A MEDICARE BENEFIT PERIOD FOR POSTHOSPITAL SKILLED NURSING FACILITY CARE ELIGIBLE UNDER MEDICARE PART A.

(D) MEDICARE PART B DEDUCTIBLE: COVERAGE FOR 100% OF THE MEDICARE PART B DEDUCTIBLE AMOUNT PER CALENDAR YEAR REGARDLESS OF HOSPITAL CONFINEMENT.

(E) ONE HUNDRED PERCENT OF THE MEDICARE PART B EXCESS CHARGES: COVERAGE FOR ALL OF THE DIFFERENCE BETWEEN THE ACTUAL MEDICARE PART B CHARGE AS BILLED, NOT TO EXCEED ANY CHARGE LIMITATION ESTABLISHED BY MEDICARE OR STATE LAW, AND THE MEDICARE-APPROVED PART B CHARGE.

(F) MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY: COVERAGE TO THE EXTENT NOT COVERED BY MEDICARE FOR 80% OF THE BILLED CHARGES FOR MEDICARE-ELIGIBLE EXPENSES FOR MEDICALLY NECESSARY EMERGENCY HOSPITAL, PHYSICIAN, AND MEDICAL CARE RECEIVED IN A FOREIGN COUNTRY, WHICH CARE WOULD HAVE BEEN COVERED BY MEDICARE IF PROVIDED IN THE UNITED STATES AND WHICH CARE BEGAN DURING THE FIRST 60 CONSECUTIVE DAYS OF EACH TRIP OUTSIDE THE UNITED STATES, SUBJECT TO A CALENDAR YEAR DEDUCTIBLE OF $250.00, AND A LIFETIME MAXIMUM BENEFIT OF $50,000.00. FOR PURPOSES OF THIS BENEFIT, "EMERGENCY CARE" MEANS CARE NEEDED IMMEDIATELY BECAUSE OF AN INJURY OR AN ILLNESS OF SUDDEN AND UNEXPECTED ONSET.

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

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

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

arrangement, and overall content of a benefit.

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

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

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

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

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

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

(e) A standardized medicare supplement benefit plan E shall include only the following: the core benefits as defined in

section 3807, the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in section 3809(1)(a), (b), (h), and (i).

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

rounded to the nearest multiple of $10.00.

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

(h) A standardized medicare supplement benefit plan H shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (f), and (h). The outpatient drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

(i) A standardized medicare supplement benefit plan I shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, 100% of the medicare part B excess charges, basic outpatient prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in section 3809(1)(a), (b), (e), (f), (h), and (j). The outpatient drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

(j) A standardized medicare supplement benefit plan J shall include only the following: the core benefits as defined in

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

(k) A standardized medicare supplement benefit plan K shall consist of only those benefits described in section 3807(2)(a).

(*l*) A standardized medicare supplement benefit plan L shall consist of only those benefits described in section 3807(2)(b).

(6) THIS SECTION APPLIES TO MEDICARE SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR ISSUED FOR DELIVERY ON OR AFTER JUNE 2, 1992 WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010.

SEC. 3811A. (1) THIS SECTION APPLIES TO ALL MEDICARE SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010.

(2) AN INSURER SHALL MAKE AVAILABLE TO EACH PROSPECTIVE MEDICARE SUPPLEMENT POLICYHOLDER AND CERTIFICATE HOLDER A POLICY FORM OR CERTIFICATE FORM CONTAINING ONLY THE BASIC CORE BENEFITS AS PROVIDED IN SECTION 3807A. IF AN INSURER MAKES AVAILABLE ANY OF THE ADDITIONAL BENEFITS DESCRIBED IN SECTION 3809A OR OFFERS STANDARDIZED BENEFIT PLANS K OR L, THE INSURER SHALL MAKE AVAILABLE TO EACH PROSPECTIVE MEDICARE SUPPLEMENT POLICYHOLDER AND CERTIFICATE HOLDER A POLICY FORM OR CERTIFICATE FORM CONTAINING EITHER STANDARDIZED BENEFIT PLAN C OR STANDARDIZED BENEFIT PLAN F.

(3) GROUPS, PACKAGES, OR COMBINATIONS OF MEDICARE SUPPLEMENT BENEFITS OTHER THAN THOSE LISTED IN THIS SECTION SHALL NOT BE OFFERED FOR SALE IN THIS STATE EXCEPT AS MAY BE PERMITTED IN SUBSECTION (6)(K).

(4) BENEFIT PLANS SHALL BE UNIFORM IN STRUCTURE, LANGUAGE, DESIGNATION, AND FORMAT TO THE STANDARD BENEFIT PLANS IN

SUBSECTION (6) AND SHALL CONFORM TO THE DEFINITIONS IN THIS CHAPTER. EACH BENEFIT SHALL BE STRUCTURED IN ACCORDANCE WITH SECTIONS 3807A AND 3809A AND LIST THE BENEFITS IN THE ORDER SHOWN IN SUBSECTION (6). FOR PURPOSES OF THIS SECTION, "STRUCTURE, LANGUAGE, AND FORMAT" MEANS STYLE, ARRANGEMENT, AND OVERALL CONTENT OF A BENEFIT.

(5) IN ADDITION TO THE BENEFIT PLAN DESIGNATIONS AS PROVIDED UNDER SUBSECTION (6), AN INSURER MAY USE OTHER DESIGNATIONS TO THE EXTENT PERMITTED BY LAW.

(6) A MEDICARE SUPPLEMENT INSURANCE BENEFIT PLAN SHALL CONFORM TO 1 OF THE FOLLOWING:

(A) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN A SHALL BE LIMITED TO THE BASIC CORE BENEFITS COMMON TO ALL BENEFIT PLANS AS DEFINED IN SECTION 3807A.

(B) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN B SHALL INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SECTION 3807A AND 100% OF THE MEDICARE PART A DEDUCTIBLE AS DEFINED IN SECTION 3809A(2)(A).

(C) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN C SHALL INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SECTION 3807A, 100% OF THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACILITY CARE, 100% OF THE MEDICARE PART B DEDUCTIBLE, AND MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY AS DEFINED IN SECTION 3809(2)(A), (C), (D), AND (F).

(D) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN D SHALL INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SECTION 3807A, 100% OF THE MEDICARE PART A DEDUCTIBLE, SKILLED

NURSING FACILITY CARE, AND MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY AS DEFINED IN SECTION 3809(2)(A), (C), AND (F).

(E) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN F SHALL INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SECTION 3807A, 100% OF THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACILITY CARE, 100% OF THE MEDICARE PART B DEDUCTIBLE, 100% OF THE MEDICARE PART B EXCESS CHARGES, AND MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY AS DEFINED IN SECTION 3809(2)(A), (C), (E), AND (F). A STANDARDIZED MEDICARE SUPPLEMENT PLAN F HIGH DEDUCTIBLE SHALL INCLUDE ONLY THE FOLLOWING: 100% OF COVERED EXPENSES FOLLOWING THE PAYMENT OF THE ANNUAL HIGH DEDUCTIBLE PLAN F DEDUCTIBLE. THE COVERED EXPENSES INCLUDE THE CORE BENEFITS AS DEFINED IN SECTION 3807A, PLUS 100% OF THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACILITY CARE, 100% OF THE MEDICARE PART B DEDUCTIBLE, 100% OF THE MEDICARE PART B EXCESS CHARGES, AND MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY AS DEFINED IN SECTION 3809(2)(A), (C), (D), (E), AND (F). THE ANNUAL HIGH DEDUCTIBLE PLAN F DEDUCTIBLE SHALL CONSIST OF OUT-OF-POCKET EXPENSES, OTHER THAN PREMIUMS, FOR SERVICES COVERED BY THE MEDICARE SUPPLEMENT PLAN F POLICY, AND SHALL BE IN ADDITION TO ANY OTHER SPECIFIC BENEFIT DEDUCTIBLES. THE ANNUAL HIGH DEDUCTIBLE PLAN F DEDUCTIBLE IS $1,500.00 FOR CALENDAR YEAR 1999, AND THE SECRETARY SHALL ADJUST IT ANNUALLY THEREAFTER TO REFLECT THE CHANGE IN THE CONSUMER PRICE INDEX FOR ALL URBAN CONSUMERS FOR THE 12-MONTH PERIOD ENDING WITH AUGUST OF THE PRECEDING YEAR, ROUNDED TO THE NEAREST MULTIPLE OF $10.00.

(F) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN G SHALL

INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SECTION 3807A, 100% OF THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACILITY CARE, 100% OF THE MEDICARE PART B EXCESS CHARGES, AND MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY AS DEFINED IN SECTION 3809(2)(A), (C), (E), AND (F).

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

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

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

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

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

(*v*) SKILLED NURSING FACILITY CARE: COVERAGE FOR 50% OF THE

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

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

(*vii*) COVERAGE FOR 50%, UNDER MEDICARE PART A OR B, OF THE REASONABLE COST OF THE FIRST 3 PINTS OF BLOOD OR EQUIVALENT QUANTITIES OF PACKED RED BLOOD CELLS, AS DEFINED UNDER FEDERAL REGULATIONS, UNLESS REPLACED IN ACCORDANCE WITH FEDERAL REGULATIONS UNTIL THE OUT-OF-POCKET LIMITATION IS MET AS DESCRIBED IN SUBPARAGRAPH (*x*).

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

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

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

SPECIFIED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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

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

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

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

(I) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN M SHALL INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SECTION 3807A AND 50% OF THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING CARE, AND MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY AS DEFINED IN SECTION 3809A(2)(B), (C), (D), AND (F).

(J) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN N SHALL INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SECTION 3807A, 100% OF THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACILITY CARE, AND MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY AS DEFINED IN SECTION 3809(2)(A), (C), AND (F) WITH COPAYMENTS IN THE FOLLOWING AMOUNTS:

(*i*) THE LESSER OF $20.00 OF THE MEDICARE PART B COINSURANCE OR COPAYMENT FOR EACH COVERED HEALTH CARE PROVIDER OFFICE VISIT, INCLUDING VISITS TO MEDICAL SPECIALISTS.

(*ii*) THE LESSER OF $50.00 OR THE MEDICARE PART B COINSURANCE OR COPAYMENT FOR EACH COVERED EMERGENCY ROOM VISIT. THE COPAYMENT SHALL BE WAIVED IF THE INSURED IS ADMITTED TO ANY HOSPITAL AND

THE EMERGENCY VISIT IS SUBSEQUENTLY COVERED AS A MEDICARE PART A EXPENSE.

(K) NEW OR INNOVATIVE BENEFITS: AN INSURER MAY, WITH THE PRIOR APPROVAL OF THE COMMISSIONER, OFFER POLICIES OR CERTIFICATES WITH NEW OR INNOVATIVE BENEFITS IN ADDITION TO THE BENEFITS PROVIDED IN A POLICY OR CERTIFICATE THAT OTHERWISE COMPLIES WITH THE APPLICABLE STANDARDS. THE NEW OR INNOVATIVE BENEFITS MAY INCLUDE BENEFITS THAT ARE APPROPRIATE TO MEDICARE SUPPLEMENT INSURANCE, NEW OR INNOVATIVE, NOT OTHERWISE AVAILABLE, COST-EFFECTIVE, AND OFFERED IN A MANNER THAT IS CONSISTENT WITH THE GOAL OF SIMPLIFICATION OF MEDICARE SUPPLEMENT POLICIES. THE INNOVATIVE BENEFIT SHALL NOT INCLUDE AN OUTPATIENT PRESCRIPTION DRUG BENEFIT. NEW OR INNOVATIVE BENEFITS SHALL NOT BE USED TO CHANGE OR REDUCE BENEFITS, INCLUDING A CHANGE OF ANY COST-SHARING PROVISION, IN ANY STANDARDIZED PLAN.

Sec. 3815. (1) An insurer that offers a medicare supplement policy shall provide to the applicant at the time of application an outline of coverage and, except for direct response solicitation policies, shall obtain an acknowledgment of receipt of the outline of coverage from the applicant. The outline of coverage provided to applicants pursuant to this section shall consist of the following 4 parts:

(a) A cover page.

(b) Premium information.

(c) Disclosure pages.

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

(2) Insurers shall comply with any notice requirements of the medicare prescription drug, improvement, and modernization act of 2003, Public Law 108-173.

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

NOTICE: Read this outline of coverage carefully.
It is not identical to the outline of coverage
provided upon application and the coverage
originally applied for has not been issued.

(4) An outline of coverage under subsection (1) shall be in the language and format prescribed in this section and in not less than 12-point type. The ~~A through L~~ letter designation of the plan shall be shown on the cover page and the plans offered by the insurer shall be prominently identified. Premium information shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and method of payment mode shall be stated for all plans that are offered to the applicant. All possible premiums for the applicant shall be illustrated. The following items shall be included in the outline of coverage in the order prescribed below and in substantially the following form, as approved by the

commissioner:

~~(Insurer Name)~~

~~Medicare Supplement Coverage~~

~~Outline of Medicare Supplement Coverage Cover Page:~~

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

~~Medicare supplement insurance can be sold in only 12 standard plans plus 2 high deductible plans. This chart shows the benefits included in each plan. Every insurer shall make available Plan "A". Some plans may not be available in your state.~~

~~**BASIC BENEFITS:** For plans A-J.~~

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

~~Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses) or copayments for hospital outpatient services.~~

~~Blood: First three pints of blood each year.~~

	~~A~~	~~B~~	~~C~~	~~D~~	~~E~~	~~F|F*~~	~~G~~	~~H~~	~~I~~	~~J|J*~~
~~Basic Benefits~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~
~~Skilled Nursing~~										
~~Co-Insurance~~			~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~
~~Part A Deductible~~		~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~
~~Part B Deductible~~			~~x~~			~~x~~				~~x~~
~~Part B Excess~~						~~x~~ ~~100%~~	~~x~~ ~~80%~~		~~x~~ ~~100%~~	~~x~~ ~~100%~~
~~Foreign Travel~~										
~~Emergency~~			~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~	~~x~~
~~At-Home Recovery~~				~~x~~			~~x~~		~~x~~	~~x~~

Preventive Care not covered by Medicare					x					x	

[COMPANY NAME]

Outline of Medicare Supplement Coverage – Cover Page 2

Basic Benefits for Plans K and L include similar services as plans A-J, but cost sharing for the basic benefits is at different levels.

	K**	L**
Basic Benefits	100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B coinsurance, except 100% coinsurance for Part B preventive	100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B coinsurance, except 100% coinsurance for Part B preventive

	~~services~~	~~services~~
~~Skilled Nursing Coinsurance~~	~~50% skilled nursing facility coinsurance~~	~~75% skilled nursing facility coinsurance~~
~~Part A Deductible~~	~~50% Part A deductible~~	~~75% Part A deductible~~
~~Part B Deductible~~		
~~Part B Excess (100%)~~		
~~Foreign Travel Emergency~~		
~~At-Home Recovery~~		
~~Preventive Care not covered by Medicare~~		
	~~$4,000 out of pocket Annual Limit***~~	~~$2,000 out of pocket Annual Limit***~~

~~*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year ($1,790) deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses exceed ($1,790). Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.~~

~~**Plans K and L provide for different cost-sharing for items and services than Plans A-J.~~

~~Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the~~

~~calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.~~

~~***The out of pocket annual limit will increase each year for inflation.~~

~~See Outlines of Coverage for details and exceptions.~~

BENEFIT CHART OF MEDICARE SUPPLEMENT PLANS SOLD ON OR AFTER JUNE 1, 2010

THIS CHART SHOWS THE BENEFITS INCLUDED IN EACH OF THE STANDARD MEDICARE SUPPLEMENT PLANS. EVERY COMPANY MUST MAKE PLAN "A" AVAILABLE. SOME PLANS MAY NOT BE AVAILABLE IN YOUR STATE.

PLANS E, H, I, AND J ARE NO LONGER AVAILABLE FOR SALE. (THIS SENTENCE SHALL NOT APPEAR AFTER JUNE 1, 2011.)

BASIC BENEFITS:
HOSPITALIZATION: PART A COINSURANCE PLUS COVERAGE FOR 365 ADDITIONAL DAYS AFTER MEDICARE BENEFITS END.
MEDICAL EXPENSES: PART B COINSURANCE (GENERALLY 20% OF MEDICARE-APPROVED EXPENSES) OR COPAYMENTS FOR HOSPITAL OUTPATIENT SERVICES. PLANS K, L, AND N REQUIRE INSUREDS TO PAY A PORTION OF PART B COINSURANCE OR COPAYMENTS.
BLOOD: FIRST THREE PINTS OF BLOOD EACH YEAR.
HOSPICE: PART A COINSURANCE

A	B	C	D	F|F*	G
BASIC, INCLUDING 100% PART B COIN-SURANCE	BASIC, INCLUDING 100% PART B COINSUR-ANCE	BASIC, INCLUDING 100% PART B COINSUR-ANCE	BASIC, INCLUDING 100% PART B COINSUR-ANCE	BASIC, INCLUDING 100% PART B COINSUR-ANCE	BASIC, INCLUDING 100% PART B COINSUR-ANCE
		SKILLED NURSING FACILITY COINSUR-ANCE	SKILLED NURSING FACILITY COINSUR-ANCE	SKILLED NURSING FACILITY COINSUR-ANCE	SKILLED NURSING FACILITY COINSUR-ANCE
	PART A DEDUCTIBLE	PART A DEDUCTIBLE	PART A DEDUCTIBLE	PART A DEDUCTIBLE	PART A DEDUCTIBLE
		PART B DEDUCTIBLE		PART B DEDUCTIBLE	
				PART B EXCESS (100%)	PART B EXCESS (100%)
		FOREIGN TRAVEL EMERGENCY	FOREIGN TRAVEL EMERGENCY	FOREIGN TRAVEL EMERGENCY	FOREIGN TRAVEL EMERGENCY

K	L	M	N
HOSPITALIZATION AND PREVENTIVE CARE PAID AT 100%; OTHER BASIC BENEFITS PAID AT 50%	HOSPITALIZATION AND PREVENTIVE CARE PAID AT 100%; OTHER BASIC BENEFITS PAID AT 75%	BASIC, INCLUDING 100% PART B COINSURANCE	BASIC, INCLUD-ING 100% PART B COINSURANCE, EXCEPT UP TO $20 COPAYMENT FOR OFFICE VISIT, AND UP TO $50 COPAY-

			MENT FOR ER
50% SKILLED NURSING FACILITY COINSURANCE	75% SKILLED NURSING FACILITY COINSURANCE	SKILLED NURSING FACILITY COINSURANCE	SKILLED NURSING FACILITY COINSURANCE
50% PART A DEDUCTIBLE	75% PART A DEDUCTIBLE	50% PART A DEDUCTIBLE	PART A DEDUCTIBLE
		FOREIGN TRAVEL EMERGENCY	FOREIGN TRAVEL EMERGENCY
OUT-OF-POCKET LIMIT $4,140; PAID AT 100% AFTER LIMIT REACHED	OUT-OF-POCKET LIMIT $2,070; PAID AT 100% AFTER LIMIT REACHED		

* PLAN F ALSO HAS AN OPTION CALLED A HIGH-DEDUCTIBLE PLAN F. THIS HIGH-DEDUCTIBLE PLAN PAYS THE SAME BENEFITS AS PLAN F AFTER ONE HAS PAID A CALENDAR YEAR $1,860 DEDUCTIBLE. BENEFITS FROM HIGH-DEDUCTIBLE PLAN F WILL NOT BEGIN UNTIL OUT-OF-POCKET EXPENSES EXCEED $1,860. OUT-OF-POCKET EXPENSES FOR THIS DEDUCTIBLE ARE EXPENSES THAT WOULD ORDINARILY BE PAID BY THE POLICY. THESE EXPENSES INCLUDE THE MEDICARE DEDUCTIBLES FOR PART A AND PART B, BUT DO NOT INCLUDE THE PLAN'S SEPARATE FOREIGN TRAVEL EMERGENCY DEDUCTIBLE.

PREMIUM INFORMATION

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

DISCLOSURES

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

THIS OUTLINE SHOWS BENEFITS AND PREMIUMS OF POLICIES SOLD FOR EFFECTIVE DATES ON OR AFTER JUNE 1, 2010. POLICIES SOLD FOR EFFECTIVE DATES PRIOR TO JUNE 1, 2010 HAVE DIFFERENT BENEFITS AND PREMIUMS. PLANS E, H, I, AND J ARE NO LONGER AVAILABLE FOR SALE. (THIS SENTENCE SHALL NOT APPEAR AFTER JUNE 1, 2011.)

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

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

NOTICE

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

[For agent issued policies]

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

[For direct response issued policies]

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is

guaranteed issue, this paragraph need not appear.]

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous			

services and supplies			
First 60 days	All but ~~$952~~ **$992**	$0	~~$952~~**$992** (Part A Deductible)
61st thru 90th day	All but ~~$238~~ **$248** a day	~~$238~~**$248** a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~$476~~ **$496** a day	~~$476~~**$496** a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$119~~	$0	Up to ~~$119~~

	$124 a day		**$124** a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~ **YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING A DOCTOR'S CERTIFICATION OF TERMINAL ILLNESS**	All but very limited **COPAYMENT/** coinsurance for outpatient drugs and inpatient respite care	~~$0~~ **MEDICARE COPAYMENT/ COINSURANCE**	~~Balance~~**$0**

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

PLAN A

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

*Once you have been billed ~~$124~~ **$131** of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First ~~$124~~**$131** of Medicare Approved Amounts*	$0	$0	~~$124~~ **$131** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD First 3 pints	$0	All Costs	$0
Next ~~$124~~**$131** of Medicare Approved Amounts*	$0	$0	~~$124~~ **$131** (Part B Deductible)

Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First ~~$124~~**$131** of Medicare Approved Amounts*	$0	$0	~~$124~~ **$131** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have

been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$952~~ **$992**	~~$952~~**$992** (Part A Deductible)	$0
61st thru 90th day	All but ~~$238~~ **$248** a day	~~$238~~**$248** a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but ~~$476~~ **$496** a day	~~$476~~**$496** a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including			

having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$119~~ **$124** a day	$0	Up to ~~$119~~ **$124** a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~**YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING A DOCTOR'S CERTIFICATION OF TERMINAL ILLNESS**	All but very limited **COPAYMENT/** coinsurance for outpatient drugs and inpatient respite care	~~$0~~ **MEDICARE COPAYMENT/ COINSURANCE**	~~Balance~~ **$0**

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

THE BALANCE BASED ON ANY DIFFERENCE BETWEEN ITS BILLED CHARGES AND THE AMOUNT MEDICARE WOULD HAVE PAID.

PLAN B

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

*Once you have been billed ~~$124~~ **$131** of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First ~~$124~~**$131** of Medicare Approved Amounts*	$0	$0	~~$124~~**$131** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges			

(Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next ~~$124~~**$131** of Medicare Approved Amounts*	$0	$0	~~$124~~**$131** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First ~~$124~~**$131** of Medicare Approved Amounts*	$0	$0	~~$124~~**$131** (Part B Deductible)
Remainder of Medicare			

Approved Amounts	80%	20%	$0

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$952~~ **$992**	~~$952~~**$992** (Part A Deductible)	$0
61st thru 90th day	All but ~~$238~~ **$248** a day	~~$238~~**$248** a day	$0
91st day and after —While using 60 lifetime reserve days	All but ~~$476~~ **$496** a day	~~$476~~**$496** a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare	$0**

		Eligible Expenses	
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$119~~ **$124** a day	Up to ~~$119~~ **$124** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE ~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~**YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING A DOCTOR'S CERTIFICATION OF**	All but very limited **COPAYMENT/** coinsurance for outpatient drugs and inpatient respite care	~~$0~~ **MEDICARE COPAYMENT/ COINSURANCE**	~~Balance~~**$0**

TERMINAL ILLNESS			

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

PLAN C

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

*Once you have been billed ~~$124~~ **$131** of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical			

equipment,			
First ~~$124~~**$131** of Medicare Approved Amounts*	$0	~~$124~~**$131** (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next ~~$124~~**$131** of Medicare Approved Amounts*	$0	~~$124~~**$131** (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary			

skilled care services			
and medical supplies	100%	$0	$0
—Durable medical equipment			
First ~~$124~~**$131** of Medicare Approved Amounts*	$0	~~$124~~**$131** (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$952~~ **$992**	~~$952~~**$992** (Part A Deductible)	$0
61st thru 90th day	All but ~~$238~~ **$248** a day	~~$238~~**$248** a day	$0
91st day and after —While using 60 lifetime reserve days	All but ~~$476~~ **$496** a day	~~$476~~**$496** a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the			

Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$119~~ **$124** a day	Up to ~~$119~~ **$124** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE ~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~**YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING A DOCTOR'S CERTIFICATION OF TERMINAL ILLNESS**	All but very limited **COPAYMENT/** coinsurance for outpatient drugs and inpatient respite care	~~$0~~**MEDICARE COPAYMENT/ COINSURANCE**	~~Balance~~**$0**

****NOTICE: WHEN YOUR MEDICARE PART A HOSPITAL BENEFITS ARE**

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

PLAN D

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

*Once you have been billed ~~$124~~**$131** of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First ~~$124~~**$131** of Medicare Approved	$0	$0	~~$124~~**$131**

Amounts*			(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next ~~$124~~**$131** of Medicare Approved Amounts*	$0	$0	~~$124~~**$131** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical			

equipment First ~~$124~~**$131** of Medicare Approved Amounts*	$0	$0	~~$124~~**$131** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
~~AT HOME RECOVERY SERVICES~~ ~~Not covered by Medicare~~ ~~Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan~~ ~~Benefit for each visit~~	~~$0~~	~~Actual Charges to $40 a visit~~	~~Balance~~
~~Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)~~	~~$0~~	~~Up to the number of Medicare Approved visits, not to exceed 7 each week~~	

~~- Calendar year maximum~~	~~$0~~	~~$1,600~~	

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

~~PLAN E~~

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $952	$952 (Part A Deductible)	$0
61st thru 90th day	All but $238 a day	$238 a day	$0
91st day and after While using 60 lifetime reserve days	All but $476 a day	$476 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within			

30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $119 a day	Up to $119 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN E

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

*Once you have been billed $124 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

~~treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,~~			
~~First $124 of Medicare Approved Amounts*~~	~~$0~~	~~$0~~	~~$124 (Part B Deductible)~~
~~Remainder of Medicare Approved Amounts~~	~~80%~~	~~20%~~	~~$0~~
~~Part B Excess Charges (Above Medicare Approved Amounts)~~	~~$0~~	~~$0~~	~~All Costs~~
~~BLOOD~~			
~~First 3 pints~~	~~$0~~	~~All Costs~~	~~$0~~
~~Next $124 of Medicare Approved Amounts*~~	~~$0~~	~~$0~~	~~$124 (Part B Deductible)~~
~~Remainder of Medicare Approved Amounts~~	~~80%~~	~~20%~~	~~$0~~
~~CLINICAL LABORATORY SERVICES - Tests for diagnostic services~~	~~100%~~	~~$0~~	~~$0~~

PARTS A & B

HOME HEALTH CARE Medicare Approved Services - Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment - First $124 of Medicare Approved Amounts*	$0	$0	$124 (Part B Deductible)
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS NOT COVERED BY MEDICARE

FOREIGN TRAVEL- Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA - First $250 each calendar year	$0	$0	$250

~~- Remainder of Charges~~	~~$0~~	~~80% to a lifetime maximum benefit of $50,000~~	~~20% and amounts over the $50,000 lifetime maximum~~
~~PREVENTIVE MEDICAL CARE BENEFIT - Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare~~			
~~- First $120 each calendar year~~	~~$0~~	~~$120~~	~~$0~~
~~- Additional charges~~	~~$0~~	~~$0~~	~~All Costs~~

PLAN F OR HIGH DEDUCTIBLE PLAN F

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

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

This high deductible plan pays the same benefits as plan F after you have paid a calendar year ~~($1,790)~~($1,860)** deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are ~~$1,790~~**$1,860**. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes medicare deductibles for part A and part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1,790~~ **$1,860** DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO ~~$1,790~~ **$1,860** DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$952~~ **$992**	~~$952~~**$992** (Part A Deductible)	$0
61st thru 90th day	All but ~~$238~~	~~$238~~**$248**	$0

	$248 a day	a day	
91st day and after			
—While using 60			
lifetime reserve days	All but ~~$476~~	~~$476~~**$496**	$0
	$496 a day	a day	
—Once lifetime reserve			
days are used:			
—Additional 365 days	$0	100% of	$0***
		Medicare	
		Eligible	
		Expenses	
—Beyond the			
Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved		
	amounts	$0	$0
21st thru 100th day	All but ~~$119~~	Up to ~~$119~~	$0
	$124 a day	**$124** a day	
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0

Additional amounts	100%	$0	$0
HOSPICE CARE ~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~**YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING A DOCTOR'S CERTIFICATION OF TERMINAL ILLNESS**	All but very limited **COPAYMENT/** coinsurance for outpatient drugs and inpatient respite care	~~$0~~**MEDICARE COPAYMENT/ COINSURANCE**	~~Balance~~**$0**

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

PLAN F

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

*Once you have been billed ~~$124~~**$131** of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

This high deductible plan pays the same benefits as plan F after you have paid a calendar year ~~($1,790)~~($1,860)** deductible. Benefits from the high deductible plan F will not begin until

out-of-pocket expenses are ~~$1,790~~**$1,860**. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes medicare deductibles for part A and part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1,790~~ **$1,860** DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO ~~$1,790~~ **$1,860** DEDUCTIBLE**, YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First ~~$124~~**$131** of Medicare Approved Amounts*	$0	~~$124~~**$131** (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare			

Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next ~~$124~~**$131** of Medicare Approved Amounts*	$0	~~$124~~**$131** (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
Medicare Approved Services			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First ~~$124~~**$131** of Medicare Approved Amounts*	$0	~~$124~~**$131** (Part B Deductible)	$0
Remainder of Medicare			

Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$952~~ **$992**	~~$952~~**$992** (Part A Deductible)	$0
61st thru 90th day	All but ~~$238~~ **$248** a day	~~$238~~**$248** a day	$0
91st day and after —While using 60 lifetime reserve days	All but ~~$476~~ **$496** a day	~~$476~~**$496** a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within			

30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$119~~ **$124** a day	Up to ~~$119~~ **$124** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~**YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING A DOCTOR'S CERTIFICATION OF TERMINAL ILLNESS**	All but very limited **COPAYMENT/** coinsurance for outpatient drugs and inpatient respite care	~~$0~~ **MEDICARE COPAYMENT/ COINSURANCE**	~~Balance~~**$0**

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

PLAN G

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

*Once you have been billed ~~$124~~**$131** of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First ~~$124~~**$131** of Medicare Approved Amounts*	$0	$0	~~$124~~**$131** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	~~80%~~**100%**	~~20%~~**0%**
BLOOD First 3 pints	$0	All Costs	$0

Next ~~$124~~**$131** of Medicare Approved Amounts*	$0	$0	~~$124~~**$131** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First ~~$124~~**$131** of Medicare Approved Amounts*	$0	$0	~~$124~~**$131** (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
~~AT-HOME RECOVERY SERVICES— Not covered by Medicare~~			

~~Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan~~			
~~—Benefit for each visit~~	~~$0~~	~~Actual Charges to $40 a visit~~	~~Balance~~
~~—Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)~~	~~$0~~	~~Up to the number of Medicare Approved visits, not to exceed 7 each week~~	
~~—Calendar year maximum~~	~~$0~~	~~$1,600~~	

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the			

first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

~~PLAN H~~

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

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

~~SERVICES~~	~~MEDICARE PAYS~~	~~PLAN PAYS~~	~~YOU PAY~~
~~HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies~~			
~~First 60 days~~	~~All but $952~~	~~$952 (Part A Deductible)~~	~~$0~~
~~61st thru 90th day~~	~~All but $238~~	~~$238~~	~~$0~~

	a day	a day	
- 91st day and after			
- While using 60			
lifetime reserve days	All but $476	$476	$0
	a day	a day	
- Once lifetime reserve			
days are used:			
- Additional 365 days	$0	100% of	$0
		Medicare	
		Eligible	
		Expenses	
- Beyond the			
Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY			
CARE*			
You must meet Medicare's			
requirements, including			
having been in a hospital			
for at least 3 days and			
entered a Medicare-			
approved facility within			
30 days after leaving the			
hospital			
- First 20 days	All approved		
	amounts	$0	$0
- 21st thru 100th day	All but $119	Up to $119	$0
	a day	a day	
- 101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

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

PLAN H

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

*Once you have been billed $124 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $124 of Medicare			

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

PARTS A & B

HOME HEALTH CARE Medicare Approved Services - Medically necessary skilled care services and medical supplies	100%	$0	$0

- Durable medical equipment First $124 of Medicare Approved Amounts*	$0	$0	$124 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS NOT COVERED BY MEDICARE

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

~~PLAN I~~

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

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

~~SERVICES~~	~~MEDICARE PAYS~~	~~PLAN PAYS~~	~~YOU PAY~~
~~HOSPITALIZATION*~~ ~~Semiprivate room and board, general nursing and miscellaneous services and supplies~~			
~~First 60 days~~	~~All but $952~~	~~$952 (Part A Deductible)~~	~~$0~~
~~61st thru 90th day~~	~~All but $238 a day~~	~~$238 a day~~	~~$0~~

- 91st day and after			
- While using 60			
lifetime reserve days	All but $476	$476	$0
	a day	a day	
- Once lifetime reserve			
days are used:			
- Additional 365 days	$0	100% of	$0
		Medicare	
		Eligible	
		Expenses	
- Beyond the			
Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY			
CARE*			
You must meet Medicare's			
requirements, including			
having been in a hospital			
for at least 3 days and			
entered a Medicare-			
approved facility within			
30 days after leaving the			
hospital			
- First 20 days	All approved		
	amounts	$0	$0
- 21st thru 100th day	All but $119	Up to $119	$0
	a day	a day	
- 101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			

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

~~PLAN I~~

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

~~*Once you have been billed $124 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.~~

~~SERVICES~~	~~MEDICARE PAYS~~	~~PLAN PAYS~~	~~YOU PAY~~
~~MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,~~			
~~First $124 of Medicare Approved Amounts*~~	~~$0~~	~~$0~~	~~$124~~

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

~~PARTS A & B~~

~~HOME HEALTH CARE Medicare Approved Services~~			
~~- Medically necessary skilled care services and medical supplies~~	~~100%~~	~~$0~~	~~$0~~
~~- Durable medical~~			

~~equipment~~			
~~First $124 of Medicare Approved Amounts*~~	~~$0~~	~~$0~~	~~$124 (Part B Deductible)~~
~~Remainder of Medicare Approved Amounts~~	~~80%~~	~~20%~~	~~$0~~
~~AT HOME RECOVERY SERVICES~~ ~~Not covered by Medicare~~ ~~Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan~~			
~~Benefit for each visit~~	~~$0~~	~~Actual Charges to $40 a visit~~	~~Balance~~
~~Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)~~	~~$0~~	~~Up to the number of Medicare Approved visits, not to exceed 7 each week~~	

- Calendar year maximum	$0	$1,600	

OTHER BENEFITS NOT COVERED BY MEDICARE

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

~~PLAN J OR HIGH DEDUCTIBLE PLAN J~~

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

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

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

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

~~services and supplies~~			
~~- First 60 days~~	~~All but $952~~	~~$952 (Part A Deductible)~~	~~$0~~
~~- 61st thru 90th day~~	~~All but $238 a day~~	~~$238 a day~~	~~$0~~
~~- 91st day and after~~			
~~- While using 60 lifetime reserve days~~	~~All but $476 a day~~	~~$476 a day~~	~~$0~~
~~- Once lifetime reserve days are used:~~			
~~- Additional 365 days~~	~~$0~~	~~100% of Medicare Eligible Expenses~~	~~$0***~~
~~- Beyond the Additional 365 days~~	~~$0~~	~~$0~~	~~All Costs~~
~~SKILLED NURSING FACILITY CARE*~~			
~~You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital~~			
~~- First 20 days~~	~~All approved amounts~~	~~$0~~	~~$0~~
~~- 21st thru 100th day~~	~~All but $119~~	~~Up to $119~~	~~$0~~

101st day and after	a day $0	a day $0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

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

PLAN J

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

*Once you have been billed $124 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,790 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $1,790 DEDUCTIBLE**, YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance
MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $124 of Medicare Approved Amounts*	$0	$124 (Part B Deductible)	$0

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

PARTS A & B

HOME HEALTH CARE Medicare Approved Services			
- Medically necessary - skilled care services and medical supplies	100%	$0	$0
- Durable medical - equipment - First $124 of Medicare			

~~Approved Amounts*~~	~~$0~~	~~$124 (Part B Deductible)~~	~~$0~~
~~Remainder of Medicare Approved Amounts~~	~~80%~~	~~20%~~	~~$0~~
~~AT-HOME RECOVERY SERVICES— Not covered by Medicare Home care certified by your doctor, for personal care beginning during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan~~			
~~Benefit for each visit~~	~~$0~~	~~Actual Charges to $40 a visit~~	~~Balance~~
~~Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)~~	~~$0~~	~~Up to the number of Medicare Approved visits, not to exceed 7 each week~~	
~~Calendar year maximum~~	~~$0~~	~~$1,600~~	

OTHER BENEFITS NOT COVERED BY MEDICARE

FOREIGN TRAVEL - Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA - First $250 each calendar year - Remainder of Charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT - Not covered by Medicare Annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare - First $120 each calendar year	$0	$120	$0

~~Additional charges~~	~~$0~~	~~$0~~	~~All costs~~

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of ~~$4,000~~**$4,140** each calendar year. The amounts that count toward your annual limit are noted with diamonds -->superscript<--1 in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing			

and miscellaneous services and supplies			
First 60 days	All but ~~$952~~ **$992**	~~$476~~**$496** (50% of Part A Deducti-ble)	~~$476~~**$496** (50% of Part A Deductible)1
61st thru 90th day	All but ~~$238~~ **$248** a day	~~$238~~ **$248** a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~$476~~ **$496** a day	~~$476~~**$496** a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the			

hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$119~~**$124** a day	Up to ~~$59.50~~**$62** a day	Up to ~~$59.50~~**$62** a day 1
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50% 1
Additional amounts	100%	$0	$0
HOSPICE CARE			
~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~**YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING A DOCTOR'S CERTIFICATION OF TERMINAL ILLNESS**	~~Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care~~ **ALL BUT VERY LIMITED COPAYMENT/ COINSURANCE FOR OUTPATIENT DRUGS AND INPATIENT RESPITE CARE**	50% of **COPAYMENT/** coinsurance ~~or copayments~~	50% of **MEDICARE COPAYMENT/** coinsurance ~~or copayments~~ 1

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an

additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

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

****Once you have been billed ~~$124~~**$131** of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First ~~$124~~**$131** of Medicare Approved Amounts****	$0	$0	~~$124~~**$131** (Part B Deductible)

			**** 1
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% 1
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of ~~$4,000~~**$4,140**)*
BLOOD			
First 3 pints	$0	50%	50% 1
Next ~~$124~~**$131** of Medicare Approved Amounts****	$0	$0	~~$124~~**$131** (Part B Deductible) **** 1
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% 1
CLINICAL LABORATORY SERVICES—Tests for diagnostic services	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to ~~$4,000~~**$4,140** per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First ~~$124~~**$131** of Medicare Approved Amounts*****	$0	$0	~~$124~~**$131** (Part B Deductible)1
Remainder of Medicare Approved Amounts	80%	10%	10% 1

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of ~~$2,000~~**$2,070** each calendar year. The amounts that count toward your annual limit are noted with diamonds -->superscript<--1 in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN L

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$952~~ **$992**	~~$714~~**$744** (75% of	~~$238~~**$248** (25% of

		Part A Deducti-ble)	Part A Deductible) 1
61st thru 90th day	All but ~~$238~~ **$248** a day	~~$238~~**$248** a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~$476~~ **$496** a day	~~$476~~**$496** a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$119~~**$124** a	Up to ~~$89.25~~**$93**	Up to ~~$29.75~~**$31**

101st day and after	day $0	a day $0	a day 1 All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 75% $0	 25% 1 $0
HOSPICE CARE ~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~**YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING A DOCTOR'S CERTIFICATION OF TERMINAL ILLNESS**	~~Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care~~**ALL BUT VERY LIMITED COPAYMENT/COINSURANCE FOR OUTPATIENT DRUGS AND INPATIENT RESPITE CARE**	75% of **COPAYMENT/** coinsurance ~~or copayments~~	25% of **COPAYMENT/** coinsurance ~~or copayments~~ 1

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

PLAN L

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

****Once you have been billed ~~$124~~**$131** of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First ~~$124~~**$131** of Medicare Approved Amounts****	$0	$0	~~$124~~**$131** (Part B Deducti-ble)**** 1
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medi-care approved amounts	All costs above Medi-care approved amounts

Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% 1
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~~**$2,070**)*
BLOOD			
First 3 pints	$0	75%	25% 1
Next ~~$124~~**$131** of Medicare Approved Amounts****	$0	$0	~~$124~~**$131** (Part B Deductible) 1
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% 1
CLINICAL LABORATORY SERVICES—Tests for diagnostic services	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to ~~$2,000~~**$2,070** per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First ~~$124~~**$131** of Medicare Approved Amounts*****	$0	$0	~~$124~~**$131** (Part B Deducti- ble) 1
Remainder of Medicare Approved Amounts	80%	15%	5% 1

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN M

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* SEMIPRIVATE ROOM AND BOARD, GENERAL NURSING AND MISCELLANEOUS SERVICES AND SUPPLIES			
FIRST 60 DAYS	ALL BUT $992	$496 (50% OF PART A DEDUC-TIBLE)	$496 (50% OF PART A DEDUC-TIBLE)
61ST THRU 90TH DAY	ALL BUT $248 A DAY	$248 A DAY	$0
91ST DAY AND AFTER:			
—WHILE USING 60 LIFETIME RESERVE DAYS	ALL BUT $496 A DAY	$496 A DAY	$0
—ONCE LIFETIME RESERVE DAYS ARE USED:			
—ADDITIONAL 365 DAYS	$0	100% OF MEDICARE ELIGIBLE EXPENSES	$0**
—BEYOND THE ADDITIONAL 365 DAYS	$0	$0	ALL COSTS
SKILLED NURSING FACILITY CARE* YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING HAVING BEEN IN A HOSPITAL FOR AT LEAST 3 DAYS AND ENTERED A MEDICARE-			

APPROVED FACILITY WITHIN 30 DAYS AFTER LEAVING THE HOSPITAL			
FIRST 20 DAYS	ALL APPROVED AMOUNTS	$0	$0
21ST THRU 100TH DAY	ALL BUT $124 A DAY	UP TO $124 A DAY	$0
101ST DAY AND AFTER	$0	$0	ALL COSTS
BLOOD			
FIRST 3 PINTS	$0	3 PINTS	$0
ADDITIONAL AMOUNTS	100%	$0	$0
HOSPICE CARE YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING A DOCTOR'S CERTIFICATION OF TERMINAL ILLNESS	ALL BUT VERY LIMITED COPAYMENT/ COINSURANCE FOR OUTPATIENT DRUGS AND INPATIENT RESPITE CARE	MEDICARE COPAYMENT/ COINSURANCE	$0

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

PLAN M

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

***ONCE YOU HAVE BEEN BILLED $131 OF MEDICARE-APPROVED AMOUNTS FOR COVERED SERVICES (WHICH ARE NOTED WITH AN ASTERISK), YOUR PART B DEDUCTIBLE WILL HAVE BEEN MET FOR THE CALENDAR YEAR.**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, SUCH AS PHYSICIAN'S SERVICES, INPATIENT AND OUTPATIENT MEDICAL AND SURGICAL SERVICES AND SUPPLIES, PHYSICAL AND SPEECH THERAPY, DIAGNOSTIC TESTS, DURABLE MEDICAL EQUIPMENT			
FIRST $131 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$131 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	GENERALLY 80%	GENERALLY 20%	$0
PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)	$0	$0	ALL COSTS

1	BLOOD			
2	FIRST 3 PINTS	$0	ALL COSTS	$0
3	NEXT $131 OF MEDICARE			
4	APPROVED AMOUNTS*	$0	$0	$131
5				(PART B
6				DEDUC-
7				TIBLE)
8	REMAINDER OF MEDICARE			
9	APPROVED AMOUNTS	80%	20%	$0
10	CLINICAL LABORATORY			
11	SERVICES—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 $131 OF			
23	MEDICARE APPROVED			
24	AMOUNTS	$0	$0	$131
25				(PART B
26				DEDUC-
27				TIBLE)
28	REMAINDER OF MEDICARE			
29	APPROVED AMOUNTS	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE MEDICALLY NECESSARY EMERGENCY CARE SERVICES BEGINNING DURING THE FIRST 60 DAYS OF EACH TRIP OUTSIDE THE USA			
FIRST $250 EACH CALENDAR YEAR	**$0**	**$0**	**$250**
REMAINDER OF CHARGES	**$0**	**80% TO A LIFETIME MAXIMUM BENEFIT OF $50,000**	**20% AND AMOUNTS OVER THE $50,000 LIFETIME MAXIMUM**

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* SEMIPRIVATE ROOM AND BOARD, GENERAL NURSING AND MISCELLANEOUS			

SERVICES AND SUPPLIES			
FIRST 60 DAYS	ALL BUT $992	$992 (PART A DEDUC-TIBLE)	$0
61ST THRU 90TH DAY	ALL BUT $248 A DAY	$248 A DAY	$0
91ST DAY AND AFTER:			
—WHILE USING 60 LIFETIME RESERVE DAYS	ALL BUT $496 A DAY	$496 A DAY	$0
—ONCE LIFETIME RESERVE DAYS ARE USED:			
—ADDITIONAL 365 DAYS	$0	100% OF MEDICARE ELIGIBLE EXPENSES	$0**
—BEYOND THE ADDITIONAL 365 DAYS	$0	$0	ALL COSTS
SKILLED NURSING FACILITY CARE* YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING HAVING BEEN IN A HOSPITAL FOR AT LEAST 3 DAYS AND ENTERED A MEDICARE-APPROVED FACILITY WITHIN 30 DAYS AFTER LEAVING THE HOSPITAL			
FIRST 20 DAYS	ALL APPROVED AMOUNTS	$0	$0

21ST THRU 100TH DAY	ALL BUT $124 A DAY	UP TO $124 A DAY	$0
101ST DAY AND AFTER	$0	$0	ALL COSTS
BLOOD			
FIRST 3 PINTS	$0	3 PINTS	$0
ADDITIONAL AMOUNTS	100%	$0	$0
HOSPICE CARE			
YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING A DOCTOR'S CERTIFICATION OF TERMINAL ILLNESS	ALL BUT VERY LIMITED COPAYMENT/ COINSURANCE FOR OUTPATIENT DRUGS AND INPATIENT RESPITE CARE	MEDICARE COPAYMENT/ COINSURANCE	$0

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

PLAN N

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

*ONCE YOU HAVE BEEN BILLED $131 OF MEDICARE-APPROVED AMOUNTS FOR COVERED SERVICES (WHICH ARE NOTED WITH AN ASTERISK), YOUR PART B DEDUCTIBLE WILL HAVE BEEN MET FOR THE CALENDAR YEAR.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, SUCH AS PHYSICIAN'S SERVICES, INPATIENT AND OUTPATIENT MEDICAL AND SURGICAL SERVICES AND SUPPLIES, PHYSICAL AND SPEECH THERAPY, DIAGNOSTIC TESTS, DURABLE MEDICAL EQUIPMENT			
FIRST $131 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$131 (PART B DEDUC-TIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	GENERALLY 80%	BALANCE, OTHER THAN UP TO $20 PER OFFICE VISIT AND UP TO $50 PER EMERGENCY ROOM VISIT. THE	UP TO $20 PER OFFICE VISIT AND UP TO $50 PER EMERGENCY ROOM VISIT. THE COPAYMENT OF UP TO

			COPAYMENT OF UP TO $50 IS WAIVED IF THE INSURED IS ADMITTED TO ANY HOSPITAL AND THE EMERGENCY VISIT IS COVERED AS A MEDICARE PART A EXPENSE.	$50 IS WAIVED IF THE INSURED IS ADMITTED TO ANY HOSPITAL AND THE EMERGENCY VISIT IS COVERED AS A MEDICARE PART A EXPENSE.
PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)	$0	$0	ALL COSTS	
BLOOD				
FIRST 3 PINTS	$0	ALL COSTS	$0	
NEXT $131 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$131 (PART B DEDUC-TIBLE)	
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0	
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0	

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—MEDICALLY NECESSARY SKILLED CARE SERVICES AND MEDICAL SUPPLIES	**100%**	**$0**	**$0**
—DURABLE MEDICAL EQUIPMENT			
FIRST $131 OF MEDICARE APPROVED AMOUNTS*	**$0**	**$0**	**$131 (PART B DEDUC-TIBLE)**
REMAINDER OF MEDICARE APPROVED AMOUNTS	**80%**	**20%**	**$0**

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE MEDICALLY NECESSARY EMERGENCY CARE SERVICES BEGINNING DURING THE FIRST 60 DAYS OF EACH TRIP OUTSIDE THE USA			
FIRST $250 EACH CALENDAR YEAR	**$0**	**$0**	**$250**
REMAINDER OF CHARGES	**$0**	**80% TO A LIFETIME**	**20% AND AMOUNTS**

		MAXIMUM BENEFIT OF $50,000	**OVER THE $50,000 LIFETIME MAXIMUM**

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

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

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

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

(c) A medicare supplement policy shall provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible, ~~amount and copayment percentage factors~~ **COPAYMENT, OR COINSURANCE AMOUNTS**. Premiums may be

modified to correspond with such changes.

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

(e) Termination of a medicare supplement policy shall not reduce or limit the payment of benefits for any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of medicare part D benefits will not be considered in determining a continuous loss.

(f) If a medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the medicare prescription drug, improvement, and modernization act of 2003, Public Law 108-173, the modified policy shall be considered to satisfy the guaranteed renewal of this subsection.

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

(3) A medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder or certificate holder for a period not to exceed 24 months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical

assistance under medicaid, but only if the policyholder or certificate holder notifies the insurer of such assistance within 90 days after the date the individual becomes entitled to the assistance. Upon receipt of timely notice, the insurer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of medicaid eligibility, subject to adjustment for paid claims. If a suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance under medicaid, the policy shall be automatically reinstituted effective as of the date of termination of the assistance if the policyholder or certificate holder provides notice of loss of medicaid medical assistance within 90 days after the date of the loss and pays the premium attributable to the period effective as of the date of termination of the assistance. Each medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of title II of the social security act, and is covered under a group health plan as defined in section 1862(b)(1)(A)(*v*) of the social security act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. All

of the following apply to the reinstitution of a medicare supplement policy under this subsection:

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

(b) Reinstituted coverage shall be substantially equivalent to coverage in effect before the date of the suspension. If the suspended medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for medicare part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of the suspension.

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

(4) IF AN INSURER MAKES A WRITTEN OFFER TO THE MEDICARE SUPPLEMENT POLICYHOLDERS OR CERTIFICATE HOLDERS OF 1 OR MORE OF ITS PLANS, TO EXCHANGE DURING A SPECIFIED PERIOD FROM HIS OR HER 1990 STANDARDIZED PLAN TO A 2010 STANDARDIZED PLAN, THE OFFER AND SUBSEQUENT EXCHANGE SHALL COMPLY WITH THE FOLLOWING REQUIREMENTS:

(A) AN INSURER NEED NOT PROVIDE JUSTIFICATION TO THE COMMISSIONER IF THE INSURED REPLACES A 1990 STANDARDIZED POLICY OR CERTIFICATE WITH AN ISSUE AGE RATED 2010 STANDARDIZED POLICY OR CERTIFICATE AT THE INSURED'S ORIGINAL ISSUE AGE AND DURATION. IF AN INSURED'S POLICY OR CERTIFICATE TO BE REPLACED IS PRICED ON

AN ISSUE AGE RATE SCHEDULE AT THAT TIME OF THAT OFFER, THE RATE CHARGED TO THE INSURED FOR THE NEW EXCHANGED POLICY SHALL RECOGNIZE THE POLICY RESERVE BUILDUP, DUE TO THE PREFUNDING INHERENT IN THE USE OF AN ISSUE AGE RATE BASIS, FOR THE BENEFIT OF THE INSURED. THE METHOD PROPOSED TO BE USED BY AN ISSUER MUST BE FILED WITH THE COMMISSIONER.

(B) THE RATING CLASS OF THE NEW POLICY OR CERTIFICATE SHALL BE THE CLASS CLOSEST TO THE INSURED'S CLASS OF THE REPLACED COVERAGE.

(C) AN INSURER MAY NOT APPLY NEW PREEXISTING CONDITION LIMITATIONS OR A NEW INCONTESTABILITY PERIOD TO THE NEW POLICY FOR THOSE BENEFITS CONTAINED IN THE EXCHANGED 1990 STANDARDIZED POLICY OR CERTIFICATE OF THE INSURED, BUT MAY APPLY PREEXISTING CONDITION LIMITATIONS OF NO MORE THAN 6 MONTHS TO ANY ADDED BENEFITS CONTAINED IN THE NEW 2010 STANDARDIZED POLICY OR CERTIFICATE NOT CONTAINED IN THE EXCHANGED POLICY.

(D) THE NEW POLICY OR CERTIFICATE SHALL BE OFFERED TO ALL POLICYHOLDERS OR CERTIFICATE HOLDERS WITHIN A GIVEN PLAN, EXCEPT WHERE THE OFFER OR ISSUE WOULD BE IN VIOLATION OF STATE OR FEDERAL LAW.

(5) THIS SECTION APPLIES TO MEDICARE SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010.

SEC. 3819A. (1) THIS SECTION APPLIES TO ALL MEDICARE SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010.

(2) AN INSURANCE POLICY SHALL NOT BE TITLED, ADVERTISED, SOLICITED, OR ISSUED FOR DELIVERY IN THIS STATE AS A MEDICARE SUPPLEMENT POLICY IF THE POLICY DOES NOT MEET THE MINIMUM STANDARDS PRESCRIBED IN THIS SECTION. THESE MINIMUM STANDARDS ARE IN ADDITION TO ALL OTHER REQUIREMENTS OF THIS CHAPTER.

(3) THE FOLLOWING STANDARDS APPLY TO MEDICARE SUPPLEMENT POLICIES:

(A) A MEDICARE SUPPLEMENT POLICY SHALL NOT DENY A CLAIM FOR LOSSES INCURRED MORE THAN 6 MONTHS FROM THE EFFECTIVE DATE OF COVERAGE BECAUSE IT INVOLVED A PREEXISTING CONDITION. THE POLICY OR CERTIFICATE SHALL NOT DEFINE A PREEXISTING CONDITION MORE RESTRICTIVELY THAN TO MEAN A CONDITION FOR WHICH MEDICAL ADVICE WAS GIVEN OR TREATMENT WAS RECOMMENDED BY OR RECEIVED FROM A PHYSICIAN WITHIN 6 MONTHS BEFORE THE EFFECTIVE DATE OF COVERAGE.

(B) A MEDICARE SUPPLEMENT POLICY SHALL NOT INDEMNIFY AGAINST LOSSES RESULTING FROM SICKNESS ON A DIFFERENT BASIS THAN LOSSES RESULTING FROM ACCIDENTS.

(C) A MEDICARE SUPPLEMENT POLICY SHALL PROVIDE THAT BENEFITS DESIGNED TO COVER COST-SHARING AMOUNTS UNDER MEDICARE WILL BE CHANGED AUTOMATICALLY TO COINCIDE WITH ANY CHANGES IN THE APPLICABLE MEDICARE DEDUCTIBLE AMOUNT AND COPAYMENT PERCENTAGE FACTORS. PREMIUMS MAY BE MODIFIED TO CORRESPOND WITH SUCH CHANGES.

(D) A MEDICARE SUPPLEMENT POLICY SHALL BE GUARANTEED RENEWABLE. TERMINATION SHALL BE FOR NONPAYMENT OF PREMIUM OR MATERIAL MISREPRESENTATION ONLY.

(E) TERMINATION OF A MEDICARE SUPPLEMENT POLICY SHALL NOT

REDUCE OR LIMIT THE PAYMENT OF BENEFITS FOR ANY CONTINUOUS LOSS THAT COMMENCED WHILE THE POLICY WAS IN FORCE, BUT THE EXTENSION OF BENEFITS BEYOND THE PERIOD DURING WHICH THE POLICY WAS IN FORCE MAY BE PREDICATED UPON THE CONTINUOUS TOTAL DISABILITY OF THE INSURED, LIMITED TO THE DURATION OF THE POLICY BENEFIT PERIOD, IF ANY, OR PAYMENT OF THE MAXIMUM BENEFITS. RECEIPT OF MEDICARE PART D BENEFITS WILL NOT BE CONSIDERED IN DETERMINING A CONTINUOUS LOSS.

(F) A MEDICARE SUPPLEMENT POLICY SHALL NOT PROVIDE FOR TERMINATION OF COVERAGE OF A SPOUSE SOLELY BECAUSE OF THE OCCURRENCE OF AN EVENT SPECIFIED FOR TERMINATION OF COVERAGE OF THE INSURED, OTHER THAN THE NONPAYMENT OF PREMIUM.

(4) A MEDICARE SUPPLEMENT POLICY SHALL PROVIDE THAT BENEFITS AND PREMIUMS UNDER THE POLICY SHALL BE SUSPENDED AT THE REQUEST OF THE POLICYHOLDER OR CERTIFICATE HOLDER FOR A PERIOD NOT TO EXCEED 24 MONTHS IN WHICH THE POLICYHOLDER OR CERTIFICATE HOLDER HAS APPLIED FOR AND IS DETERMINED TO BE ENTITLED TO MEDICAL ASSISTANCE UNDER MEDICAID, BUT ONLY IF THE POLICYHOLDER OR CERTIFICATE HOLDER NOTIFIES THE INSURER OF SUCH ASSISTANCE WITHIN 90 DAYS AFTER THE DATE THE INDIVIDUAL BECOMES ENTITLED TO THE ASSISTANCE. UPON RECEIPT OF TIMELY NOTICE, THE INSURER SHALL RETURN TO THE POLICYHOLDER OR CERTIFICATE HOLDER THAT PORTION OF THE PREMIUM ATTRIBUTABLE TO THE PERIOD OF MEDICAID ELIGIBILITY, SUBJECT TO ADJUSTMENT FOR PAID CLAIMS. IF A SUSPENSION OCCURS AND IF THE POLICYHOLDER OR CERTIFICATE HOLDER LOSES ENTITLEMENT TO MEDICAL ASSISTANCE UNDER MEDICAID, THE POLICY SHALL BE AUTOMATICALLY REINSTITUTED EFFECTIVE AS OF THE DATE OF

TERMINATION OF THE ASSISTANCE IF THE POLICYHOLDER OR CERTIFICATE HOLDER PROVIDES NOTICE OF LOSS OF MEDICAID MEDICAL ASSISTANCE WITHIN 90 DAYS AFTER THE DATE OF THE LOSS AND PAYS THE PREMIUM ATTRIBUTABLE TO THE PERIOD EFFECTIVE AS OF THE DATE OF TERMINATION OF THE ASSISTANCE. EACH MEDICARE SUPPLEMENT POLICY SHALL PROVIDE THAT BENEFITS AND PREMIUMS UNDER THE POLICY SHALL BE SUSPENDED AT THE REQUEST OF THE POLICYHOLDER IF THE POLICYHOLDER IS ENTITLED TO BENEFITS UNDER SECTION 226(B) OF TITLE II OF THE SOCIAL SECURITY ACT AND IS COVERED UNDER A GROUP HEALTH PLAN AS DEFINED IN SECTION 1862(B)(1)(A)(V) OF THE SOCIAL SECURITY ACT. IF SUSPENSION OCCURS AND IF THE POLICYHOLDER OR CERTIFICATE HOLDER LOSES COVERAGE UNDER THE GROUP HEALTH PLAN, THE POLICY SHALL BE AUTOMATICALLY REINSTITUTED EFFECTIVE AS OF THE DATE OF LOSS OF COVERAGE IF THE POLICYHOLDER PROVIDES NOTICE OF LOSS OF COVERAGE WITHIN 90 DAYS AFTER THE DATE OF THE LOSS AND PAYS THE PREMIUM ATTRIBUTABLE TO THE PERIOD, EFFECTIVE AS OF THE DATE OF TERMINATION OF ENROLLMENT IN THE GROUP HEALTH PLAN. ALL OF THE FOLLOWING APPLY TO THE REINSTITUTION OF A MEDICARE SUPPLEMENT POLICY UNDER THIS SUBSECTION:

(A) THE REINSTITUTION SHALL NOT PROVIDE FOR ANY WAITING PERIOD WITH RESPECT TO TREATMENT OF PREEXISTING CONDITIONS.

(B) REINSTITUTED COVERAGE SHALL BE SUBSTANTIALLY EQUIVALENT TO COVERAGE IN EFFECT BEFORE THE DATE OF THE SUSPENSION.

(C) CLASSIFICATION OF PREMIUMS FOR REINSTITUTED COVERAGE SHALL BE ON TERMS AT LEAST AS FAVORABLE TO THE POLICYHOLDER OR CERTIFICATE HOLDER AS THE PREMIUM CLASSIFICATION TERMS THAT WOULD HAVE APPLIED TO THE POLICYHOLDER OR CERTIFICATE HOLDER HAD THE

COVERAGE NOT BEEN SUSPENDED.

Sec. 3831. (1) Each insurer offering individual or group expense incurred hospital, medical, or surgical policies or certificates in this state shall provide without restriction, to any person who requests coverage from an insurer and has been insured with an insurer subject to this section, if the person would no longer be insured because he or she has become eligible for medicare or if the person loses coverage under a group policy after becoming eligible for medicare, a right of continuation or conversion to their choice of the basic core benefits as described in section 3807 **OR 3807A** or a type C medicare supplemental package as described in section 3811(5)(c) **OR 3811A(6)(C)** that is guaranteed renewable or noncancellable. A person who is hospitalized or has been informed by a physician that he or she will require hospitalization within 30 days after the time of application shall not be entitled to coverage under this subsection until the day following the date of discharge. However, if the hospitalized person was insured by the insurer immediately prior to becoming eligible for medicare or immediately prior to losing coverage under a group policy after becoming eligible for medicare, the person shall be eligible for immediate coverage from the previous insurer under this subsection. A person shall not be entitled to a medicare supplemental policy under this subsection unless the person presents satisfactory proof to the insurer that he or she was insured with an insurer subject to this section. A person who wishes coverage under this subsection must either request

coverage within 90 days before or 90 days after the month he or she becomes eligible for medicare or request coverage within 180 days after losing coverage under a group policy. A person 60 years of age or older who loses coverage under a group policy is entitled to coverage under a medicare supplemental policy without restriction from the insurer providing the former group coverage, if he or she requests coverage within 90 days before or 90 days after the month he or she becomes eligible for medicare.

(2) Except as provided in section 3833, a person not insured under an individual or group hospital, medical, or surgical expense incurred policy as specified in subsection (1), after applying for coverage under a medicare supplemental policy required to be offered under subsection (1), shall be entitled to coverage under a medicare supplemental policy that may include a provision for exclusion from preexisting conditions for 6 months after the inception of coverage, consistent with the provisions of section 3819(2)(a) **OR 3819A(3)(A)**.

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

this section.

(4) Notwithstanding the requirements of this section, an insurer offering or renewing individual or group expense incurred hospital, medical, or surgical policies or certificates after June 27, 2005 may comply with the requirement of providing medicare supplemental coverage to eligible policyholders by utilizing another insurer to write this coverage provided the insurer meets all of the following requirements:

(a) The insurer provides its policyholders the name of the insurer that will provide the medicare supplemental coverage.

(b) The insurer gives its policyholders the telephone numbers at which the medicare supplemental insurer can be reached.

(c) The insurer remains responsible for providing medicare supplemental coverage to its policyholders in the event that the other insurer no longer provides coverage and another insurer is not found to take its place.

(d) The insurer provides certification from an executive officer for the specific insurer or affiliate of the insurer wishing to utilize this option. This certification shall identify the process provided in subdivisions (a) through (c) and shall clearly state that the insurer understands that the commissioner may void this arrangement if the affiliate fails to ensure that eligible policyholders are immediately offered medicare supplemental policies.

(e) The insurer certifies to the commissioner that it is in the process of discontinuing in Michigan its offering of

individual or group expense incurred hospital, medical, or surgical policies or certificates.

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

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

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

(4) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of

termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(5) If a medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the medicare prescription drug, improvement, and modernization act of 2003, Public Law 108-173, the modified policy shall be considered to satisfy the guaranteed renewal requirements of this section.