SUBSTITUTE FOR

HOUSE BILL NO. 6431

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending sections 2266, 3801, 3803, 3811a, 3813, 3815, 3819a, 3827, 3829, 3831, 3835, 3843, and 3847 (MCL 500.2266, 500.3801, 500.3803, 500.3811a, 500.3813, 500.3815, 500.3819a, 500.3827, 500.3829, 500.3831, 500.3835, 500.3843, and 500.3847), section 2266 as added by 2018 PA 205, sections 3801, 3803, 3815, and 3831 as amended and sections 3811a and 3819a as added by 2009 PA 220, sections 3813, 3843, and 3847 as added by 1992 PA 84, sections 3827 and 3835 as amended by 2006 PA 462, and section 3829 as amended by 2002 PA 304, and by adding section 3811b; and to repeal acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 2266. (1) Subject to the requirements of this section,

a notice to a party or any other document that is required in an insurance transaction or that is to serve as evidence of insurance coverage may be delivered, stored, and presented by electronic means if it meets ~~both of the following:~~

~~(a) The~~ **THE** requirements of the uniform electronic transactions act, 2000 PA 305, MCL 450.831 to 450.849.

~~(b) For a health insurer, the requirements of section 2236(9)(a)(*ii*).~~

(2) Electronic delivery of a notice or document as provided in this section is equivalent to any delivery method otherwise required by law, including delivery by first-class mail, first-class mail postage prepaid, certified mail, or certificate of mailing.

(3) If an insurer has reason to believe that a party is not receiving notices or documents that the insurer attempts to deliver by electronic means, including if the insurer attempts delivery by electronic means and receives a notice that the delivery by electronic means has failed, the insurer shall deliver the notices or documents by first-class mail or by any other delivery method required for the notices or documents.

(4) An insurer may use electronic delivery of a notice or a document to a party under this section if the insurer meets the requirements of subsection (5) and if all of the following requirements are met:

(a) The party has affirmatively consented to the electronic delivery method and has not withdrawn consent.

(b) Before obtaining consent, the insurer provides the party

with a clear and conspicuous statement informing the party of all of the following:

(*i*) The right of the party at any time to have the notice or the document provided or made available in paper form or by another nonelectronic form.

(*ii*) The right of the party at any time to withdraw consent to have a notice or document delivered by electronic means and any conditions or consequences imposed if consent is withdrawn.

(*iii*) The specific notice or document or categories of notices or documents that may be delivered by electronic means during the course of the relationship between the insurer and the party.

(*iv*) The means, after consent is given, by which the party may obtain a paper copy of a notice or document delivered by electronic means.

(*v*) The procedures for the party to follow to update information needed to contact the party electronically and to withdraw consent to have a notice or a document delivered by electronic means.

(c) Before obtaining consent, the insurer provides the party with a statement of the hardware and software requirements for access to and retention of a notice or document delivered by electronic means. The party shall provide electronic consent to the hardware and software requirements or confirm consent electronically in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means.

(5) After the party consents as provided in subsection (4),

if a change occurs in hardware or software needed to access or retain a notice or document delivered by electronic means that creates a material risk that the party will not be able to access or retain a notice or document to which consent applies, the insurer shall provide the party with a statement that includes all of the following:

(a) Information regarding the revised hardware or software requirements for access to and retention of a notice or document delivered by electronic means.

(b) A description of the right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed under subsection (4)(b)(*ii*).

(6) Withdrawal of consent to electronic delivery does not affect the legal effectiveness, validity, or enforceability of a notice or a document that is delivered by electronic means to a party before the withdrawal of consent is effective.

(7) Except as otherwise provided in this subsection, withdrawal of consent by a party becomes effective 30 days after the insurer receives notice of the withdrawal. Consent is automatically withdrawn if the insurer learns that the electronic delivery method currently used is no longer an effective delivery mechanism.

(8) Failure by an insurer to comply with subsection (5) may be treated, at the election of the party, as a withdrawal of consent.

(9) This section must not be construed to modify, limit, or supersede the federal electronic signatures in global national

commerce act, 15 USC 7001 to 7031.

(10) An insurance producer is not subject to civil liability for any harm or injury to a party that occurs as a result of either of the following:

(a) The party's consent under subsection (4) to receive a notice or a document delivered by electronic means under this section.

(b) An insurer's failure to deliver a notice or document by electronic means unless the insurance producer causes the harm or injury.

(11) THIS SECTION DOES NOT APPLY TO A HEALTH INSURER OR HEALTH MAINTENANCE ORGANIZATION.

(12) ~~(11)~~ As used in this section:

(a) "Delivered by electronic means", "delivery by electronic means", or "electronic delivery" mean delivery by either of the following methods:

(*i*) Delivery to an electronic mail address at which a party has consented to receive notices or documents.

(*ii*) Both of the following:

(A) Posting on an electronic network or site accessible by the internet through use of a mobile application, computer, mobile device, tablet, or any other electronic device.

(B) Sending separate notice of the posting described in sub-subparagraph (A) to the electronic mail address at which the party consented to receive notice of the posting or using any other delivery method to which the party has consented.

(b) "Party" means a recipient of a notice or document

required as part of an insurance transaction and includes an applicant, insured, policy holder, or annuity contract holder.

Sec. 3801. As used in this chapter:

(a) "Applicant" means:

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

(*ii*) For a group ~~medicare~~ **MEDICARE** supplement policy or certificate, the proposed certificate holder.

(b) "Bankruptcy" means, ~~when~~ **WITH RESPECT TO** a ~~medicare~~ **MEDICARE** advantage organization that is not an insurer, **THAT THE ORGANIZATION** 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~~ **MEDICARE** supplement policy.

(d) "Certificate form" means the form on which ~~the~~ **A** certificate is delivered or issued for delivery by ~~the~~ **AN** 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.~~**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.~~**1110B.**

(*vi*) A medical care program of the Indian ~~health service~~ **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(c) of title I of the peace corps act,~~ 22 USC ~~2504.~~**2504(E).**

(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~~ **WITH RESPECT TO** an insurer licensed to transact the business of insurance in this state, **THAT THE INSURER** 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~~ **PERSON THAT DELIVERS** or ~~issuing~~ **ISSUES** for delivery in this state ~~medicare~~ **MEDICARE** supplement policies.

(k) "Medicaid" means ~~title~~ **SUBCHAPTER** XIX of the social security act, 42 USC 1396 to ~~1396v.~~**1396W-5.**

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

(m) "Medicare advantage" means a plan of coverage for health benefits under ~~medicare~~ **MEDICARE** part C as ~~defined~~ **DESCRIBED** 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~~ **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",~~ **"CHOOSING A MEDIGAP POLICY: A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE"**, developed by the ~~national association of insurance commissioners~~ **NATIONAL ASSOCIATION OF INSURANCE**

COMMISSIONERS and the United States ~~department of health and human services~~ **DEPARTMENT OF HEALTH AND HUMAN SERVICES**, or a substantially similar document as approved by the ~~commissioner.~~**DIRECTOR.**

(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~~ **MEDICARE** for the hospital, medical, or surgical expenses of persons eligible for ~~medicare~~ **MEDICARE** and ~~medicare~~ **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~~ **MEDICARE** advantage plans established under ~~medicare~~ **MEDICARE** part C, outpatient prescription drug plans established under ~~medicare~~ **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.~~**42 USC 1395*l*(A)(1).**

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

(q) "Prestandardized ~~medicare~~ **MEDICARE** supplement benefit plan", "prestandardized benefit plan", or "prestandardized plan" means a group or individual policy of ~~medicare~~ **MEDICARE**

supplement insurance issued ~~prior to~~ **BEFORE** June 2, 1992.

(r) "1990 standardized ~~medicare~~ **MEDICARE** supplement benefit plan", "1990 standardized benefit plan", or "1990 plan" means a group or individual policy of ~~medicare~~ **MEDICARE** supplement insurance issued on or after June 2, 1992 with an effective date for coverage ~~prior to~~ **BEFORE** June 1, 2010 and includes ~~medicare~~ **MEDICARE** supplement insurance policies and certificates renewed on or after that date ~~which~~ **THAT** are not replaced by the issuer at the request of the insured.

(s) "2010 standardized ~~medicare~~ **MEDICARE** supplement benefit plan", "2010 standardized benefit plan", or "2010 plan" means a group or individual policy of ~~medicare~~ **MEDICARE** supplement insurance with an effective date for coverage on or after June 1, 2010.

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

(u) "Secretary" means the secretary of the United States ~~department of health and human services.~~**DEPARTMENT OF HEALTH AND HUMAN SERVICES.**

(v) "Social security act" means the social security act, 42 USC 301 to ~~1397jj.~~**1397MM.**

Sec. 3803. (1) Except as provided in subsections (2) and (3), this chapter applies to a ~~medicare~~ **MEDICARE** supplement policy delivered, issued for delivery, or renewed in this state.

(2) Sections 3807, 3809, 3811, and 3819 apply to a ~~medicare~~ **MEDICARE** supplement policy delivered or issued for delivery in this state on or after June 2, 1992 with an effective date for

coverage ~~prior to~~ **BEFORE** June 1, 2010.

(3) Sections 3807a, 3809a, 3811a, and 3819a apply to a ~~medicare~~ **MEDICARE** supplement policy delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010.

Sec. 3811a. (1) This section applies to all ~~medicare~~ **MEDICARE** supplement policies or certificates delivered or issued for delivery with an effective date for coverage on or after June 1, 2010. A policy or certificate ~~shall~~ **MUST** not be advertised, solicited, delivered, or issued for delivery in this state as a ~~medicare~~ **MEDICARE** supplement policy or certificate unless it complies with these benefit standards. Benefit plan standards applicable to ~~medicare~~ **MEDICARE** supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of section 3811.

(2) An insurer shall make available to each prospective ~~medicare~~ **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~~ **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~~ **MEDICARE** supplement benefits other than those listed in this section ~~shall~~

MUST not be offered for sale in this state except as may be permitted in subsection (6)(k).

(4) Benefit plans ~~shall~~ **MUST** be uniform in structure, language, designation, and format to the standard benefit plans in subsection (6) and ~~shall~~ **MUST** conform to the definitions in this chapter. Each benefit ~~shall~~ **MUST** be structured in accordance with sections 3807a and 3809a and list the benefits in the order shown in subsection (6). ~~For purposes of~~ **AS USED IN** this section, "structure, language, **DESIGNATION**, 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~~ **MEDICARE** supplement insurance benefit plan ~~shall~~ **MUST** conform to 1 of the following:

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

(b) A standardized ~~medicare~~ **MEDICARE** supplement benefit plan B ~~shall~~ **MUST** include only the following: the core benefits as ~~defined in~~ **REQUIRED UNDER** section 3807a and 100% of the ~~medicare~~ **MEDICARE** part A deductible as defined in section 3809a(2)(a).

(c) A standardized ~~medicare~~ **MEDICARE** supplement benefit plan C ~~shall~~ **MUST** include only the following: the core benefits as ~~defined in~~ **REQUIRED UNDER** section 3807a ~~,~~ **AND** 100% of the ~~medicare~~ **MEDICARE** part A deductible, skilled nursing facility care, 100% of the ~~medicare~~ **MEDICARE** part B deductible, and

medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (d), and (f).

(d) A standardized ~~medicare~~ **MEDICARE** supplement benefit plan D ~~shall~~ **MUST** include only the following: the core benefits as ~~defined in~~ **REQUIRED UNDER** section 3807a ~~,~~ **AND** 100% of the ~~medicare~~ **MEDICARE** part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), and (f).

(e) A standardized ~~medicare~~ **MEDICARE** supplement benefit plan F ~~shall~~ **MUST** include only the following: the core benefits as ~~defined in~~ **REQUIRED UNDER** section 3807a ~~,~~ **AND** 100% of the ~~medicare~~ **MEDICARE** part A deductible, skilled nursing facility care, 100% of the ~~medicare~~ **MEDICARE** part B deductible, 100% of the ~~medicare~~ **MEDICARE** part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (d), (e), and (f). A standardized ~~medicare~~ **MEDICARE** supplement plan F high deductible ~~shall~~ **MUST** include only the following: 100% of covered expenses following the payment of the annual ~~high deductible~~ **HIGH-DEDUCTIBLE** plan F deductible. The covered expenses include the core benefits as ~~defined in~~ **REQUIRED UNDER** section 3807a ~~, plus~~ **AND** 100% of the ~~medicare~~ **MEDICARE** part A deductible, skilled nursing facility care, 100% of the ~~medicare~~ **MEDICARE** part B deductible, 100% of the ~~medicare~~ **MEDICARE** part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (d), (e), and (f). The annual ~~high deductible~~ **HIGH-DEDUCTIBLE** plan F deductible ~~shall~~ **MUST** consist

of out-of-pocket expenses, other than premiums, for services covered by the ~~medicare~~ **MEDICARE** supplement plan F policy, and ~~shall~~ **MUST** be in addition to any other specific benefit deductibles. The annual ~~high deductible~~ **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~~ **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~~ **MEDICARE** supplement benefit plan G ~~shall~~ **MUST** include only the following: the core benefits as ~~defined in~~ **REQUIRED UNDER** section 3807a ~~,~~ **AND** 100% of the ~~medicare~~ **MEDICARE** part A deductible, skilled nursing facility care, 100% of the ~~medicare~~ **MEDICARE** part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (e), and (f). **EFFECTIVE JANUARY 1, 2020, THE STANDARDIZED PLAN F HIGH DEDUCTIBLE BENEFIT PLAN, REDESIGNATED IN SECTION 3811B(2)(D) AS PLAN G HIGH DEDUCTIBLE, MAY BE OFFERED TO AN INDIVIDUAL WHO WAS ELIGIBLE FOR MEDICARE BEFORE JANUARY 1, 2020.**

(g) Standardized ~~medicare~~ **MEDICARE** supplement benefit plan K ~~shall~~ **MUST** 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~~ **MEDICARE** benefit period.

(*ii*) Coverage of 100% of the part A hospital coinsurance amount for each ~~medicare~~ **MEDICARE** lifetime inpatient reserve day

used from the ninety-first day through the one hundred fiftieth day in any ~~medicare~~ **MEDICARE** benefit period.

(*iii*) ~~Upon~~ **ON** exhaustion of the ~~medicare~~ **MEDICARE** hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the ~~medicare~~ **MEDICARE** part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate ~~medicare~~ **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~~ **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~~ **MEDICARE** benefit period for posthospital skilled nursing facility care eligible under ~~medicare~~ **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~~ **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~~ **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~~ **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~~ **MEDICARE** part B preventive services after the policyholder pays the part B deductible.

(*x*) Coverage of 100% of all cost sharing under ~~medicare~~ **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~~ **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.~~**DEPARTMENT OF HEALTH AND HUMAN SERVICES.**

(h) Standardized ~~medicare~~ **MEDICARE** supplement benefit plan L ~~shall~~ **MUST** 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~~ **MEDICARE** supplement benefit plan M ~~shall~~ **MUST** include only the following: the core benefits as ~~defined in~~ **REQUIRED UNDER** section 3807a and 50% of the ~~medicare~~ **MEDICARE** part A deductible, skilled nursing care, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(b), (c), and (f).

(j) A standardized ~~medicare~~ **MEDICARE** supplement benefit plan N ~~shall~~ **MUST** include only the following: the core benefits as ~~defined in~~ **REQUIRED UNDER** section 3807a ~~,~~ **AND** 100% of the ~~medicare~~ **MEDICARE** part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), and (f) with copayments in the following amounts:

(*i*) The lesser of $20.00 or the ~~medicare~~ **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~~ **MEDICARE** part B coinsurance or copayment for each covered emergency room visit. The copayment ~~shall~~ **MUST** be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a ~~medicare~~ **MEDICARE** part A expense.

(k) New or innovative benefits: an insurer may, with the prior approval of the ~~commissioner,~~ **DIRECTOR**, 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~~

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~~ **MEDICARE** supplement policies. The innovative benefit ~~shall~~ **MUST** not include an outpatient prescription drug benefit. New or innovative benefits ~~shall~~ **MUST** not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

SEC. 3811B. (1) THIS SECTION APPLIES TO ALL MEDICARE SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE TO INDIVIDUALS NEWLY ELIGIBLE FOR MEDICARE AFTER DECEMBER 31, 2019. A POLICY OR CERTIFICATE THAT PROVIDES COVERAGE OF THE MEDICARE PART B DEDUCTIBLE MUST NOT BE ADVERTISED, SOLICITED, DELIVERED, OR ISSUED FOR DELIVERY IN THIS STATE AS A MEDICARE SUPPLEMENT POLICY OR CERTIFICATE TO INDIVIDUALS NEWLY ELIGIBLE FOR MEDICARE AFTER DECEMBER 31, 2019, UNLESS IT COMPLIES WITH THE BENEFIT STANDARDS PROVIDED IN THIS SECTION. BENEFIT PLAN STANDARDS APPLICABLE TO MEDICARE SUPPLEMENT POLICIES AND CERTIFICATES ISSUED TO INDIVIDUALS ELIGIBLE FOR MEDICARE BEFORE JANUARY 1, 2020 REMAIN SUBJECT TO THE REQUIREMENTS OF SECTION 3811A.

(2) THE STANDARDS AND REQUIREMENTS OF SECTION 3811A APPLY TO ALL MEDICARE SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR ISSUED FOR DELIVERY TO INDIVIDUALS NEWLY ELIGIBLE FOR MEDICARE AFTER DECEMBER 31, 2019, WITH THE FOLLOWING EXCEPTIONS:

(A) STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN C IS REDESIGNATED AS PLAN D AND MUST PROVIDE THE BENEFITS CONTAINED IN

SECTION 3811A(6)(C), BUT MUST NOT PROVIDE COVERAGE FOR 100% OR ANY PORTION OF THE MEDICARE PART B DEDUCTIBLE.

(B) STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN F IS REDESIGNATED AS PLAN G AND MUST PROVIDE THE BENEFITS CONTAINED IN SECTION 3811A(6)(E), AS APPLICABLE, BUT MUST NOT PROVIDE COVERAGE FOR 100% OR ANY PORTION OF THE MEDICARE PART B DEDUCTIBLE.

(C) STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLANS C, F, AND F HIGH DEDUCTIBLE MAY NOT BE OFFERED TO INDIVIDUALS NEWLY ELIGIBLE FOR MEDICARE AFTER DECEMBER 31, 2019.

(D) STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN F HIGH DEDUCTIBLE IS REDESIGNATED AS PLAN G HIGH DEDUCTIBLE AND MUST PROVIDE THE BENEFITS IN SECTION 3811A(6)(E), AS APPLICABLE, BUT MUST NOT PROVIDE COVERAGE FOR 100% OR ANY PORTION OF THE MEDICARE PART B DEDUCTIBLE. THE MEDICARE PART B DEDUCTIBLE PAID BY THE BENEFICIARY IS CONSIDERED AN OUT-OF-POCKET EXPENSE IN MEETING THE ANNUAL HIGH DEDUCTIBLE.

(E) THE REFERENCE TO PLAN C OR PLAN F CONTAINED IN SECTION 3811A(2) IS DEEMED A REFERENCE TO PLAN D OR PLAN G, RESPECTIVELY, FOR PURPOSES OF THIS SECTION.

(3) THIS SECTION ONLY APPLIES TO INDIVIDUALS THAT ARE NEWLY ELIGIBLE FOR MEDICARE AFTER DECEMBER 31, 2019 BECAUSE OF EITHER OF THE FOLLOWING:

(A) BY REASON OF ATTAINING AGE 65 AFTER DECEMBER 31, 2019.

(B) BY REASON OF ENTITLEMENT TO BENEFITS UNDER MEDICARE PART A UNDER SECTION 226(B) OR 226A OF THE SOCIAL SECURITY ACT, OR WHO IS DEEMED TO BE ELIGIBLE FOR BENEFITS UNDER SECTION 226A OF THE SOCIAL SECURITY ACT AFTER DECEMBER 31, 2019.

(4) FOR PURPOSES OF SECTION 3830(5) TO (8), FOR AN INDIVIDUAL NEWLY ELIGIBLE FOR MEDICARE AFTER DECEMBER 31, 2019, ANY REFERENCE TO MEDICARE SUPPLEMENT POLICY OR CERTIFICATE PLANS C, F, OR F HIGH DEDUCTIBLE IS DEEMED TO BE A REFERENCE TO MEDICARE SUPPLEMENT POLICY OR CERTIFICATE PLANS D, G, OR G HIGH DEDUCTIBLE, RESPECTIVELY, THAT MEET THE REQUIREMENTS OF SUBSECTION (2).

(5) AFTER DECEMBER 31, 2019, THE STANDARDIZED BENEFIT PLANS DESCRIBED IN SUBSECTION (2)(D) MAY BE OFFERED TO AN INDIVIDUAL WHO WAS ELIGIBLE FOR MEDICARE BEFORE JANUARY 1, 2020, IN ADDITION TO THE STANDARDIZED PLANS DESCRIBED IN SECTION 3811A(6).

Sec. 3813. An insurer that issues a policy that provides ~~disability~~ **HEALTH INSURANCE** coverage to a person eligible for ~~medicare~~ **MEDICARE** by reason of age shall provide the prospective policyholder with a ~~medicare~~ **MEDICARE** supplement buyer's guide **IN WRITTEN OR ELECTRONIC FORMAT,** which ~~shall~~ **MUST** be furnished at the time of application, and **THE INSURER SHALL OBTAIN, IN WRITTEN OR ELECTRONIC FORMAT,** acknowledgment of receipt of the buyer's guide. ~~shall be obtained by the insurer.~~ However, for direct response solicitation policies, the guide ~~shall~~ **MUST** be furnished with the policy **IN WRITTEN OR ELECTRONIC FORMAT** and **THE INSURER NEED NOT OBTAIN** acknowledgment of receipt. ~~need not be obtained by the insurer.~~ This section does not apply to policies that provide accidental death benefits for travel or other accidents, or if the medical expense or indemnity payments are only incidental to the accidental death benefits for travel or other accidents.

Sec. 3815. (1) An insurer that offers a ~~medicare~~ **MEDICARE** supplement policy shall provide to the applicant at the time of application an outline of coverage **IN WRITTEN OR ELECTRONIC FORMAT** and, except for direct response solicitation policies, shall obtain an acknowledgment of receipt of the outline of coverage from the applicant **IN WRITTEN OR ELECTRONIC FORMAT**. The outline of coverage provided to applicants ~~pursuant to~~ **UNDER** this section ~~shall~~ **MUST** 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~~ **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~~ **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~~ **MUST** accompany the policy or certificate when it is delivered and ~~shall~~ **MUST** contain the following statement, in ~~no~~ **NOT** 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~~ **ON** application and the coverage originally applied for has not been issued.

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

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~~ **MUST** 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/G*
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	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	Foreign	Foreign	Foreign

		Travel Emergency	Travel Emergency	Travel Emergency	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, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment 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;~~ **$5,240;** paid at 100%	Out-of-pocket limit ~~$2,070;~~ **$2,620;** paid at 100%		

after limit reached	after limit reached			

* ~~Plan~~ **PLANS** F **AND G** also ~~has an option~~ **HAVE OPTIONS** called ~~a~~ high-deductible Plan F ~~. This~~ **AND HIGH-DEDUCTIBLE PLAN G. THESE** high-deductible ~~plan pays~~ **PLANS PAY** the same benefits as Plan F **OR PLAN G, AS APPLICABLE,** after one has paid a calendar year ~~$1,860~~ **$2,240** deductible. Benefits from high-deductible Plan F **OR HIGH-DEDUCTIBLE PLAN G** will not begin until out-of-pocket expenses exceed ~~$1,860.~~ **$2,240.** Out-of-pocket expenses for ~~this deductible~~ **THESE DEDUCTIBLES** 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.

**** PLAN C, PLAN F, AND HIGH-DEDUCTIBLE PLAN F ARE ONLY AVAILABLE TO INDIVIDUALS ELIGIBLE FOR MEDICARE BEFORE JANUARY 1, 2020.**

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~~ **BEFORE** June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. (This sentence ~~shall~~ **MUST** 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.~~**MEDICARE.**

[For direct response issued policies]

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

This outline of coverage does not give all the details of ~~medicare~~ **MEDICARE** coverage. Contact your local social security office or consult ~~"the medicare handbook"~~ **"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~~ **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~~ **UNDER** 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.~~ **DIRECTOR.** 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 ~~$992~~**$1,340**	$0	~~$992~~**$1,340** (Part A Deductible)
61st thru 90th day	All but ~~$248~~**$335** a day	~~$248~~**$335** a day	$0

91st day and after:			
—While using 60 lifetime reserve days	All but ~~$496~~**$670** a day	~~$496~~**$670** 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~~**$167.50** a day	$0	Up to ~~$124~~**$167.50** a day
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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 A

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

*Once you have been billed ~~$131~~ **$183** 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~~ **$183** of Medicare Approved Amounts*	$0	$0	~~$131~~**$183** (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 ~~$131~~ **$183** of Medicare Approved Amounts*	$0	$0	~~$131~~**$183** (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 ~~$131~~ **$183** of Medicare Approved Amounts*	$0	$0	~~$131~~**$183** (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 ~~$992~~**$1,340**	~~$992~~**$1,340** (Part A Deductible)	$0
61st thru 90th day	All but ~~$248~~ **$335** a day	~~$248~~**$335** a day	$0
91st day and after —While using 60 lifetime reserve days	All but ~~$496~~ **$670** a day	~~$496~~**$670** 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~~**$167.50** a day	$0	Up to ~~$124~~ **$167.50** a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE 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 B

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

*Once you have been billed ~~$131~~ **$183** 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~~ **$183** of			

Medicare Approved Amounts*	$0	$0	~~$131~~**$183** (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 ~~$131~~ **$183** of Medicare Approved Amounts*	$0	$0	~~$131~~**$183** (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 ~~$131~~ **$183** of Medicare Approved Amounts*	$0	$0	~~$131~~**$183** (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 ~~$992~~**$1,340**	~~$992~~**$1,340** (Part A Deductible)	$0
61st thru 90th day	All but	~~$248~~**$335**	$0

	~~$248~~ **$335** a day	a day	
91st day and after —While using 60 lifetime reserve days	All but ~~$496~~ **$670** a day	~~$496~~**$670** 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~~**$167.50** a day	Up to ~~$124~~**$167.50** a day	$0
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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 C

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

*Once you have been billed ~~$131~~ **$183** 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~~ **$183** of Medicare Approved Amounts*	$0	~~$131~~**$183** (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 ~~$131~~ **$183** of Medicare Approved Amounts*	$0	~~$131~~**$183** (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 ~~$131~~ **$183** of Medicare Approved Amounts*	$0	~~$131~~**$183** (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 ~~$992~~**$1,340**	~~$992~~**$1,340** (Part A Deductible)	$0
61st thru 90th day	All but ~~$248~~ **$335** a day	~~$248~~**$335** a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but ~~$496~~ **$670** a day	~~$496~~**$670** 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~~ **$167.50** a day	Up to ~~$124~~**$167.50** **A DAY**	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE 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 D

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

*Once you have been billed ~~$131~~ **$183** 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~~ **$183** of Medicare Approved Amounts*	$0	$0	~~$131~~**$183** (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 ~~$131~~ **$183** of Medicare Approved Amounts*	$0	$0	~~$131~~**$183** (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 ~~$131~~ **$183** of Medicare Approved Amounts*	$0	$0	~~$131~~**$183** (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 F OR ~~HIGH DEDUCTIBLE~~ **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~~ **HIGH-DEDUCTIBLE plan pays the same benefits as plan F after you have paid a calendar year ~~($1,860)~~

$2,240 deductible. Benefits from the ~~high deductible~~ **HIGH-DEDUCTIBLE** plan F will not begin until out-of-pocket expenses are ~~$1,860.~~ **$2,240.** Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes ~~medicare~~ **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 ~~$1,860~~**$2,240** DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO ~~$1,860~~**$2,240** DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$992~~**$1,340**	~~$992~~**$1,340** (Part A Deductible)	$0
61st thru 90th day	All but ~~$248~~ **$335** a day	~~$248~~**$335** a day	$0
91st day and after —While using 60 lifetime reserve days	All but ~~$496~~ **$670** a day	~~$496~~**$670** 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~~**$167.50** a day	Up to ~~$124~~**$167.50** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			

	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0
You must meet Medicare's requirements, including a doctor's certification of 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 F

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

*Once you have been billed ~~$131~~ **$183** 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~~ **HIGH-DEDUCTIBLE plan pays the same benefits as plan F after you have paid a calendar year ~~($1,860)~~ **$2,240** deductible. Benefits from the ~~high deductible~~ **HIGH-DEDUCTIBLE** plan F will not begin until out-of-pocket expenses are ~~$1,860.~~ **$2,240.** Out-of-pocket expenses for this deductible are

expenses that would ordinarily be paid by the policy. This includes ~~medicare~~ **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 ~~$1,860~~**$2,240** DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO ~~$1,860~~**$2,240** 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 ~~$131~~ **$183** of Medicare Approved Amounts*	$0	~~$131~~**$183** (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 ~~$131~~ **$183** of Medicare Approved Amounts*	$0	~~$131~~**$183** (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 ~~$131~~ **$183** of Medicare Approved Amounts*	$0	~~$131~~**$183** (Part B	$0

		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 G **OR HIGH-DEDUCTIBLE 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.

**** THIS HIGH-DEDUCTIBLE PLAN PAYS THE SAME BENEFITS AS PLAN G AFTER ONE HAS PAID A CALENDAR YEAR $2,240 DEDUCTIBLE. BENEFITS FROM THE HIGH-DEDUCTIBLE PLAN G WILL NOT BEGIN UNTIL OUT-OF-POCKET EXPENSES ARE $2,240. OUT-OF-POCKET EXPENSES FOR THIS DEDUCTIBLE INCLUDE EXPENSES FOR THE MEDICARE PART B DEDUCTIBLE, AND EXPENSES THAT WOULD ORDINARILY BE PAID BY THE POLICY. THIS DOES NOT INCLUDE THE PLAN'S SEPARATE FOREIGN TRAVEL EMERGENCY DEDUCTIBLE.**

		AFTER YOU PAY $2,240 DEDUCTIBLE, **	**IN ADDITION TO $2,240 DEDUCTIBLE, ****
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~~**$1,340**	~~$992~~**$1,340** (Part A Deductible)	$0
61st thru 90th day	All but ~~$248~~**$335** a day	~~$248~~**$335** a day	$0
91st day and after			

—While using 60 lifetime reserve days	All but ~~$496~~**$670** a day	~~$496~~**$670** 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~~**$167.50** a day	Up to ~~$124~~**$167.50** a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0

Additional amounts	100%	$0	$0
HOSPICE CARE 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 G **OR HIGH-DEDUCTIBLE PLAN G**

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

*Once you have been billed ~~$131~~ **$183** 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 G AFTER ONE HAS PAID A CALENDAR YEAR $2,240 DEDUCTIBLE. BENEFITS FROM THE HIGH-DEDUCTIBLE PLAN G WILL NOT BEGIN UNTIL OUT-OF-**

POCKET EXPENSES ARE $2,240. OUT-OF-POCKET EXPENSES FOR THIS DEDUCTIBLE INCLUDE EXPENSES FOR THE MEDICARE PART B DEDUCTIBLE, AND EXPENSES THAT WOULD ORDINARILY BE PAID BY THE POLICY. THIS DOES NOT INCLUDE THE PLAN'S SEPARATE FOREIGN TRAVEL EMERGENCY DEDUCTIBLE.

			AFTER YOU PAY $2,240 DEDUCTIBLE, **	**IN ADDITION TO PAY $2,240 DEDUCTIBLE, ****
	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~~ **$183** of Medicare Approved	$0	$0	~~$131~~**$163**

Amounts*			(**UNLESS** Part B Deductible **HAS BEEN MET**)
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 ~~$131~~ **$183** of Medicare Approved Amounts*	$0	$0	~~$131~~**$183** (**UNLESS** Part B Deductible **HAS BEEN MET**)
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~~ **$183** of			
Medicare Approved	$0	$0	~~$131~~**$183**
Amounts*			(**UNLESS**
			Part B
			Deductible
			HAS BEEN
			MET)
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 K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of ~~$4,140~~ **$5,240** each calendar year. The amounts that count toward your annual limit are noted with diamonds[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 ~~$992~~**$1,340**	~~$496~~**$670** (50% of Part A Deducti-ble)	~~$496~~**$670** (50% of Part A Deductible) 1
61st thru 90th day	All but ~~$248~~ **$335** a day	~~$248~~**$335** a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~$496~~ **$670** a day	~~$496~~**$670** 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~~ **$167.50** a day	Up to ~~$62~~**$83.75** a day	Up to ~~$62~~**$83.75** 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				
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited	50% of copayment/ coinsur-ance	50% of Medicare copayment/ coinsurance 1	

	copayment/ coinsurance for outpatient drugs and inpatient respite care		

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

PLAN K

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

****Once you have been billed ~~$131~~ **$183** 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~~ **$183** of Medicare Approved Amounts****	$0	$0	~~$131~~**$183** (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 ~~$4,140)*~~

			$5,240)*
BLOOD			
First 3 pints	$0	50%	50% 1
Next ~~$131~~ **$183** of Medicare Approved Amounts****	$0	$0	~~$131~~**$183** (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 ~~$4,140~~ **$5,240** 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 ~~$131~~ **$183** of Medicare Approved Amounts*****	$0	$0	~~$131~~**$183** (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 ~~$2,070~~ **$2,620** each calendar year. The amounts that count toward your annual limit are noted with diamonds[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 ~~$992~~**$1,340**	~~$744~~**$1,005** (75% of Part A Deducti-ble)	~~$248~~**$335** (25% of Part A Deductible) 1
61st thru 90th day	All but ~~$248~~ **$335** a day	~~$248~~**$335** a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~$496~~ **$670** a day	~~$496~~**$670** a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible	$0***

		Expenses	
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$124~~ **$167.50** a day	Up to ~~$93~~**$125.63** a day	Up to ~~$31~~**$41.88** a day 1
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25% 1
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements,		75% of copayment/ coinsur-ance	25% of copayment/ coinsurance 1

including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care		

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

PLAN L

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

****Once you have been billed ~~$131~~ **$183** 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~~ **$183** of Medicare Approved Amounts****	$0	$0	~~$131~~**$183** (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 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 ~~$2,070)*~~ **$2,620)***
BLOOD First 3 pints	$0	75%	25% 1
Next ~~$131~~ **$183** of Medicare Approved Amounts****	$0	$0	~~$131~~**$183** (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 ~~$2,070~~ **$2,620** 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 ~~$131~~ **$183** of Medicare Approved Amounts*****	$0	$0	~~$131~~**$183** (Part B Deductible) 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~~ **$1,340**	~~$496~~**$670** **(50%** of Part A Deduc-tible)	~~$496~~**$670** **(50%** of Part A Deduc-tible)
61st thru 90th day	All but ~~$248~~ **$335** a day	~~$248~~**$335** a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~$496~~ **$670** a day	~~$496~~**$670** 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~~ **$167.50** a day	Up to ~~$124~~ **$167.50** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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~~ **$183** 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~~**$183** of Medicare Approved Amounts*	$0	$0	~~$131~~**$183** (Part B Deduc-tible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges			

(Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next ~~$131~~ **$183** of Medicare Approved Amounts*	$0	$0	~~$131~~**$183** (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~~ **$183** of Medicare Approved Amounts	$0	$0	~~$131~~**$183**

			(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 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~~ **$1,340**	~~$992~~**$1,340** (Part A Deduc-tible)	$0
61st thru 90th day	All but ~~$248~~ **$335** a day	~~$248~~**$335** a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~$496~~ **$670** a day	~~$496~~**$670** 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~~ **$167.50** a day	Up to ~~$124~~ **$167.50** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE 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~~ **$183** 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~~**$183**			

of Medicare Approved Amounts*	$0	$0	~~$131~~**$183** (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 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	Up to $20 per office visit and up to $50 per emergency room visit. The 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.

		expense.	
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next ~~$131~~**$183** of Medicare Approved Amounts*	$0	$0	~~$131~~**$183** (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~~ **$183** of			

Medicare Approved Amounts*	$0	$0	~~$131~~**$183** (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 maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Sec. 3819a. (1) This section applies to all ~~medicare~~ **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~~ **MUST** not be titled, advertised, solicited, or issued for delivery in this state as a ~~medicare~~ **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. An issuer shall not offer any 1990 plan for sale on or after June 1, 2010. Benefit standards applicable to ~~medicare~~ **MEDICARE** supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of section 3819.

(3) The following standards apply to ~~medicare~~ **MEDICARE** supplement policies:

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

(c) A ~~medicare~~ **MEDICARE** supplement policy ~~shall~~ **MUST** provide that benefits designed to cover cost-sharing amounts under ~~medicare~~ **MEDICARE** will be changed automatically to coincide with

any changes in the applicable ~~medicare~~ **MEDICARE** deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

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

(e) Termination of a ~~medicare~~ **MEDICARE** supplement policy ~~shall~~ **MUST** 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~~ **ON** 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~~ **MEDICARE** part D benefits will not be considered in determining a continuous loss.

(f) A ~~medicare~~ **MEDICARE** supplement policy ~~shall~~ **MUST** 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~~ **MEDICARE** supplement policy ~~shall~~ **MUST** provide that benefits and premiums under the policy ~~shall~~ **WILL** 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,~~ **MEDICAID,** but only if the policyholder or certificate holder notifies the insurer of ~~such~~ **THE** assistance within 90 days after

the date the individual becomes entitled to the assistance. ~~Upon~~ **ON** 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~~ **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,~~ **MEDICAID,** the policy ~~shall~~ **MUST** 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~~ **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~~ **A MEDICARE** supplement policy ~~shall~~ **MUST** provide that benefits and premiums under the policy ~~shall~~ **WILL** 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~~ **42 USC 426(B),** and is covered under a group health plan as defined in ~~section 1862(b)(1)(A)(v) of the social security act.~~ **42 USC 1395Y(B)(1)(A)(*v*).** If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy ~~shall~~ **MUST** 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~~ **MEDICARE** supplement policy under this subsection:

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

(b) Reinstituted coverage ~~shall~~ **MUST** be substantially equivalent to coverage in effect before the date of the suspension.

(c) Classification of premiums for reinstituted coverage ~~shall~~ **MUST** 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. 3827. (1) A ~~medicare~~ **MEDICARE** supplement insurance policy or certificate ~~shall~~ **MUST** not be delivered or issued for delivery in this state if the policy or certificate provides benefits that duplicate benefits provided by ~~medicare.~~**MEDICARE.**

(2) Application forms or a supplementary application or other form to be signed by the applicant and agent for ~~medicare~~ **MEDICARE** supplement policies, ~~shall~~ **WHICH MAY BE PROVIDED IN WRITTEN OR ELECTRONIC FORMAT, MUST** include the following statements and questions designed to inform and elicit information as to whether, ~~as of~~ **ON** the date of the application, the applicant ~~currently~~ has ~~medicare~~ **MEDICARE** supplement, ~~medicare~~ **MEDICARE** advantage, ~~medicaid~~ **MEDICAID** coverage, or another health insurance policy or certificate in force or whether a ~~medicare~~ **MEDICARE** supplement policy or certificate is intended to replace any ~~disability or other~~ health policy or certificate presently in force:

[STATEMENTS]

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

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

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

(4) If, after purchasing this policy, you become eligible for ~~medicaid,~~ **MEDICAID**, the benefits and premiums under your ~~medicare~~ **MEDICARE** supplement policy will be suspended during your entitlement to benefits under ~~medicaid~~ **MEDICAID** for 24 months. You must request this suspension within 90 days ~~of~~ **AFTER** becoming eligible for ~~medicaid.~~ **MEDICAID.** If you are no longer entitled to ~~medicaid,~~ **MEDICAID**, your suspended ~~medicare~~ **MEDICARE** supplement policy, or, if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days ~~of~~ **AFTER** losing ~~medicaid~~ **MEDICAID** eligibility. If the ~~medicare~~ **MEDICARE** supplement provided coverage for outpatient prescription drugs and you enrolled in ~~medicare~~ **MEDICARE** part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in, a ~~medicare~~ **MEDICARE** supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your ~~medicare~~ **MEDICARE** supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your ~~medicare~~ **MEDICARE** supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended ~~medicare~~ **MEDICARE** supplement policy, or if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days ~~of~~ **AFTER** losing your employer or union-based group health plan. If the ~~medicare~~ **MEDICARE** supplement policy provided coverage for outpatient prescription drugs and you enrolled in ~~medicare~~ **MEDICARE** part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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

[QUESTIONS]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a ~~medicare~~ **MEDICARE** supplement insurance policy, or that you had certain rights to buy such a

policy, you may be guaranteed acceptance in one or more of our ~~medicare~~ **MEDICARE** supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X"]

To the best of your knowledge,

(1) (a) Did you turn age 65 in the last 6 months?

Yes ____ No ____

(b) Did you enroll in ~~medicare~~ **MEDICARE** part B in the last 6 months?

Yes ____ No ____

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state ~~medicaid~~ **MEDICAID** program?

[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes ____ No ____

If yes,

(a) Will ~~medicaid~~ **MEDICAID** pay your premiums for this ~~medicare~~ **MEDICARE** supplement policy?

Yes ____ No ____

(b) Do you receive any benefits from ~~medicaid~~ **MEDICAID** OTHER THAN payments toward your ~~medicare~~ **MEDICARE** part B premium?

Yes ____ No ____

(3) (a) If you had coverage from any ~~medicare~~ **MEDICARE** plan other than original ~~medicare~~ **MEDICARE** within the

past 63 days (for example, a ~~medicare~~ **MEDICARE** advantage plan, or a ~~medicare~~ **MEDICARE** HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

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

(b) If you are still covered under the ~~medicare~~ **MEDICARE** plan, do you intend to replace your current coverage with this new ~~medicare~~ **MEDICARE** supplement policy?

Yes ____ No ____

(c) Was this your first time in this type of ~~medicare~~ **MEDICARE** plan?

Yes ____ No ____

(d) Did you drop a ~~medicare~~ **MEDICARE** supplement policy to enroll in the ~~medicare~~ **MEDICARE** plan?

Yes ____ No ____

(4) (a) Do you have another ~~medicare~~ **MEDICARE** supplement policy in force?

Yes ____ No ____

(b) If so, with what company, and what plan do you have [optional for direct mailers]?

_____

(c) If so, do you intend to replace your current ~~medicare~~ **MEDICARE** supplement policy with this policy?

Yes ____ No ____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes ____ No ____

(a) If so, with what company and what kind of policy?

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy?

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

(If you are still covered under the other policy, leave "END" blank.)

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

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

(5) ~~Upon~~ **ON** determining that a sale will involve replacement of ~~medicare~~ **MEDICARE** supplement coverage, an insurer, other than a direct response insurer or its agent, shall furnish the applicant ~~prior to~~ **BEFORE** issuance or delivery of the ~~medicare~~ **MEDICARE** supplement policy the following notice regarding

replacement of ~~medicare~~ **MEDICARE** supplement coverage. One copy of the notice signed by the applicant and the agent, ~~except where~~ **UNLESS THE** coverage is sold without an agent, ~~shall~~ **MUST** be provided to the applicant and an additional signed copy ~~shall~~ **MUST** be retained by the insurer. A direct response insurer shall deliver to the applicant at the time of issuance of the policy or certificate the following notice, regarding replacement of ~~medicare~~ **MEDICARE** supplement coverage. The notice regarding replacement of ~~medicare~~ **MEDICARE** supplement coverage ~~shall~~ **MUST** be provided in substantially the following form and in not less than 12-point type:

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

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

You should review this new coverage carefully comparing it with all disability and other health coverage you now have and terminate your present coverage only if, after due consideration, you find that purchase of this ~~medicare~~ **MEDICARE** supplement

coverage is a wise decision.

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

(Use additional sheets as necessary.)

I have reviewed your current medical or health coverage. The replacement of coverage involved in this transaction does not duplicate your existing ~~medicare~~ **MEDICARE** supplement, or, if applicable, ~~medicare~~ **MEDICARE** advantage coverage because you intend to terminate your existing ~~medicare~~ **MEDICARE** supplement coverage or leave your ~~medicare~~ **MEDICARE** advantage plan, to the best of my knowledge. The replacement policy is being purchased for the following reasons (check 1):

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ My plan has outpatient prescription drug coverage and I am enrolling in part D

_____ Disenrollment from a ~~medicare~~ **MEDICARE** advantage plan. Please explain reason for disenrollment. [Optional only for direct mailers.]

_____ Other. (Please specify)

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

application of a new pre-existing condition limitation.

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

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

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

_____

Signature of Agent, Broker, or Other Representative

(* Signature not required for direct response sales.)

_____

Typed Name and Address of Agent or Broker

_____

(Date)

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

_____

(Date)

_____

(Applicant's Signature)

_____

(Applicant's Printed Name)

_____

(Applicant's Address)

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

Sec. 3829. (1) An insurer shall not deny or condition the issuance or effectiveness of a ~~medicare~~ **MEDICARE** supplement policy available for sale in this state, or discriminate in the pricing of such a policy, because of the health status, claims experience, receipt of health care, or medical condition of an applicant if an application for the policy is submitted during the 6-month period beginning with the first month in which an individual who is 65 years of age or older ~~first~~ enrolled for benefits under ~~medicare~~ **MEDICARE** part B. Each ~~medicare~~ **MEDICARE** supplement policy currently available from an insurer ~~shall~~ **MUST** be made available to all applicants who qualify under this section without regard to age.

(2) If an applicant qualifies under subsection (1), submits an application during the time period provided in subsection (1), and as of the date of application has had a continuous period of creditable coverage of not less than 6 months, the insurer shall not exclude benefits based on a preexisting condition. If the applicant qualifies under subsection (1), submits an application during the time period in subsection (1), and as of the date of application has had a continuous period of creditable coverage that is less than 6 months, the insurer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subsection.

(3) Except as provided in subsection (2) and section 3833, subsection (1) does not prevent the exclusion of benefits under a policy, during the first 6 months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the 6 months before the coverage became effective.

(4) ~~"Creditable~~ **AS USED IN THIS SECTION, "CREDITABLE** coverage" does not include any of the following:

(a) One or more of the following:

(*i*) Coverage only for accident or disability income insurance, or any combination of accident or disability income insurance.

(*ii*) Coverage issued as a supplement to liability insurance.

(*iii*) Liability insurance, including general liability

insurance and automobile liability insurance.

(*iv*) Workers' compensation or similar insurance.

(*v*) Automobile medical payment insurance.

(*vi*) Credit-only insurance.

(*vii*) Coverage for on-site medical clinics.

(*viii*) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(b) The following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(*i*) Limited scope dental or vision benefits.

(*ii*) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of long-term care, nursing home care, home health care, or community-based care.

(*iii*) Such other similar, limited benefits as are specified in federal regulations.

(c) The following benefits if offered as independent, noncoordinated benefits:

(*i*) Coverage only for a specified disease or illness.

(*ii*) Hospital indemnity or other fixed indemnity insurance.

(d) The following if it is offered as a separate policy, certificate, or contract of insurance:

(*i*) Medicare supplemental policy as defined ~~under section 1882(g)(1) of part D of medicare,~~ **IN** 42 ~~U.S.C.~~ **USC** 1395ss.

(*ii*) Coverage supplemental to the coverage provided under

chapter 55 of title 10 of the United States Code, 10 ~~U.S.C.~~ **USC** 1071 to ~~1109.~~**1110B.**

(*iii*) Similar supplemental coverage provided to coverage under a group health plan.

Sec. 3831. (1) Each insurer offering ~~individual or~~ group expense incurred hospital, medical, or surgical policies or certificates in this state shall ~~provide~~ **MAKE AVAILABLE** 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,~~ **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)~~ **1 OF THE FOLLOWING MEDICARE SUPPLEMENT PLANS** that is guaranteed renewable or noncancellable: ~~.~~

(A) A POLICY FORM OR CERTIFICATE FORM THAT CONTAINS THE BASIC CORE BENEFITS AS DESCRIBED IN SECTION 3807 OR 3807A.

(B) A POLICY FORM OR CERTIFICATE FORM THAT THE INSURER HAS CHOSEN TO OFFER THAT CONTAINS EITHER STANDARDIZED BENEFIT PLAN C OR STANDARDIZED BENEFIT PLAN F. FOR AN INDIVIDUAL NEWLY ELIGIBLE FOR MEDICARE AFTER DECEMBER 31, 2019, ANY REFERENCE TO STANDARDIZED BENEFIT PLAN C OR STANDARDIZED BENEFIT PLAN F IS DEEMED A REFERENCE TO MEDICARE SUPPLEMENT STANDARDIZED BENEFIT PLAN D OR MEDICARE SUPPLEMENT STANDARDIZED BENEFIT PLAN G, RESPECTIVELY.

(2) 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~~ **IS** not ~~be~~ entitled to coverage under ~~this~~ subsection **(1)** 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~~ **BEFORE** losing coverage under a group policy after becoming eligible for ~~medicare,~~ **MEDICARE,** the person ~~shall be~~ **IS** eligible for immediate coverage from the previous insurer under ~~this~~ subsection **(1).** A person ~~shall~~ **IS** not ~~be~~ entitled to a ~~medicare~~ **MEDICARE** supplemental policy under ~~this~~ subsection **(1)** 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 **(1)** 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~~ **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.~~**MEDICARE.**

(3) ~~(2)~~ Except as provided in section 3833, a person not insured under ~~an individual or~~ **A** group hospital, medical, or surgical expense incurred policy as specified in subsection (1), after applying for coverage under a ~~medicare~~ **MEDICARE**

supplemental policy required to be offered under subsection (1), ~~shall be~~ **IS** entitled to coverage under a ~~medicare~~ **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).

(4) ~~(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,~~ **MEDICARE**, written notice of the availability of coverage under this section.

(5) ~~(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~~ **MEDICARE** supplemental coverage to eligible policyholders by utilizing another insurer to write this coverage ~~provided~~ **IF** the insurer meets all of the following requirements:

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

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

(c) The insurer remains responsible for providing ~~medicare~~ **MEDICARE** supplemental coverage to its policyholders ~~in the event that~~ **IF** 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~~ **MUST** identify the process provided in subdivisions (a) ~~through~~ **TO** (c) and ~~shall~~ **MUST** clearly state that the insurer understands that the ~~commissioner~~ **DIRECTOR** may void this arrangement if the affiliate fails to ensure that eligible policyholders are immediately offered ~~medicare~~ **MEDICARE** supplemental policies.

(e) ~~The~~ **IF THE INSURER IS UNABLE TO MEET THE REQUIREMENTS OF SUBDIVISIONS (A) TO (D), THE** insurer certifies to the ~~commissioner~~ **DIRECTOR** that it is in the process of discontinuing in ~~Michigan~~ **THIS STATE** its offering of individual or group expense incurred hospital, medical, or surgical policies or certificates.

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

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

(b) Establish marketing procedures to ensure excessive

insurance is not sold or issued.

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

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

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

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

(4) An insurer shall not issue a ~~medicare~~ **MEDICARE** supplement policy or certificate to an individual enrolled in ~~medicare~~ **MEDICARE** advantage unless the effective date of the coverage is after the termination date of the individual's ~~medicare~~ **MEDICARE** advantage coverage.

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

Sec. 3843. (1) ~~Any~~ **A** policy or certificate of ~~disability~~ **HEALTH** insurance issued for delivery in this state to persons eligible for ~~medicare~~ **MEDICARE** by reason of age ~~shall~~ **MUST** notify insureds under the policy or certificate that the policy is not a

~~medicare~~ **MEDICARE** supplement policy. The notice ~~shall~~ **MUST** either be printed or attached to the first page of the coverage outline delivered to insureds under the policy or certificate ~~,~~ or, if a coverage outline is not delivered, to the first page of the policy or certificate delivered to insureds. The notice ~~shall~~ **MUST** be in not less than 12-point type, and ~~shall~~ **MUST** contain the following language:

"This (policy or certificate) is not a ~~medicare~~ **MEDICARE** supplement (policy or certificate). It is not designed to fit with ~~medicare.~~ **MEDICARE.** It may not fit all of the gaps in ~~medicare~~ **MEDICARE** and it may duplicate some ~~medicare~~ **MEDICARE** benefits. If you are eligible for ~~medicare,~~ **MEDICARE,** review the ~~medicare~~ **MEDICARE** supplement buyer's guide available from the company. If you decide to consider buying this policy or certificate, be sure you understand what it covers, what it does not cover, and whether it duplicates coverage you already have."

(2) Subsection (1) does not apply to any of the following:

(a) A ~~medicare~~ **MEDICARE** supplement policy or certificate.

(b) A disability income policy or certificate.

(c) A single premium nonrenewable policy or certificate.

Sec. 3847. ~~Each~~ **AN** insurer ~~providing medicare~~ **THAT PROVIDES MEDICARE** supplement insurance coverage in this state shall file with the ~~commissioner~~ **DIRECTOR** for review a copy of any written, radio, or television advertisement for ~~medicare~~ **MEDICARE** supplement insurance intended for use in this state at least ~~45~~ **30** days before the date the insurer desires to use the advertising. The filing ~~shall~~ **MUST** include a sample or photocopy

of all applicable ~~medicare~~ **MEDICARE** supplement policies and related forms and the approval status of the policies and forms.

Enacting section 1. Sections 3804 and 3808 of the insurance code of 1956, 1956 PA 218, MCL 500.3804 and 500.3808, are repealed.

Enacting section 2. This amendatory act takes effect 90 days after the date it is enacted into law.