

HOUSE BILL No. 6431

October 4, 2018, Introduced by Rep. Vaupel and referred to the Committee on Health Policy.

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending sections 3801, 3803, 3807a, 3809, 3809a, 3811a, 3813, 3815, 3819a, 3827, 3829, 3831, 3835, 3839, 3843, and 3847 (MCL 500.3801, 500.3803, 500.3807a, 500.3809, 500.3809a, 500.3811a, 500.3813, 500.3815, 500.3819a, 500.3827, 500.3829, 500.3831, 500.3835, 500.3839, 500.3843, and 500.3847), sections 3801, 3803, 3809, 3815, 3831, and 3839 as amended and sections 3807a, 3809a, 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:

1 Sec. 3801. As used in this chapter:

2 (a) "Applicant" means:

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

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

7 (b) "Bankruptcy" means, ~~when~~**WITH RESPECT TO** a ~~medicare~~
8 **MEDICARE** advantage organization that is not an insurer, **THAT THE**
9 **ORGANIZATION** has filed, or has had filed against it, a petition
10 for declaration of bankruptcy and has ceased doing business in
11 this state.

12 (c) "Certificate" means any certificate delivered or issued
13 for delivery in this state under a group ~~medicare~~**MEDICARE**
14 supplement policy.

15 (d) "Certificate form" means the form on which ~~the~~**A**
16 certificate is delivered or issued for delivery by ~~the~~**AN**
17 insurer.

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

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

24 (i) A group health plan.

25 (ii) Health insurance coverage.

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

27 (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(e) 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.~~ **1395III**.

(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

1 substantially similar document as approved by the
 2 ~~commissioner.~~**DIRECTOR.**

3 (o) "Medicare supplement policy" means an individual ~~7~~
 4 ~~nongroup,~~ or group policy or certificate that is advertised,
 5 marketed, or designed primarily as a supplement to reimbursements
 6 under ~~medicare~~**MEDICARE** for the hospital, medical, or surgical
 7 expenses of persons eligible for ~~medicare~~**MEDICARE** and ~~medicare~~
 8 **MEDICARE** select policies and certificates under section 3817.

9 Medicare supplement policy does not include a policy,
 10 certificate, or contract of 1 or more employers or labor
 11 organizations, or of the trustees of a fund established by 1 or
 12 more employers or labor organizations, or both, for employees or
 13 former employees, or both, or for members or former members, or
 14 both, of the labor organizations. Medicare supplement policy does
 15 not include ~~medicare~~**MEDICARE** advantage plans established under
 16 ~~medicare~~**MEDICARE** part C, outpatient prescription drug plans
 17 established under ~~medicare~~**MEDICARE** part D, or any health care
 18 prepayment plan that provides benefits pursuant to an agreement
 19 under ~~section 1833(a)(1)(A) of the social security act.~~**42 USC**
 20 **1395f(a)(1) .**

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

23 (q) "Prestandardized ~~medicare~~**MEDICARE** supplement benefit
 24 plan", "prestandardized benefit plan", or "prestandardized plan"
 25 means a group or individual policy of ~~medicare~~**MEDICARE**
 26 supplement insurance issued ~~prior to~~**BEFORE** June 2, 1992.

27 (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. 3807a. (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. 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 3807.

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

(a) Coverage of part A ~~medicare eligible~~**MEDICARE-ELIGIBLE** expenses for hospitalization to the extent not covered by ~~medicare~~**MEDICARE** from the sixty-first day through the ninetieth day in any ~~medicare~~**MEDICARE** benefit period.

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

(c) Upon 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.

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

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

(f) Coverage of cost sharing for all part A ~~medicare-eligible~~ **MEDICARE-ELIGIBLE** hospice care and respite care expenses.

Sec. 3809. (1) In addition to the basic core package of benefits required under section 3807, the following benefits may

1 be included in a ~~medicare~~**MEDICARE** supplement insurance policy
2 and if included ~~shall~~**MUST** conform to section 3811(5) (b) to (j):

3 (a) Medicare part A deductible: coverage for all of the
4 ~~medicare~~**MEDICARE** part A inpatient hospital deductible amount per
5 benefit period.

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

11 (c) Medicare part B deductible: coverage for all of the
12 ~~medicare~~**MEDICARE** part B deductible amount per calendar year
13 regardless of hospital confinement.

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

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

24 (f) Basic outpatient prescription drug benefit: coverage for
25 50% of outpatient prescription drug charges, after a \$250.00
26 calendar year deductible, to a maximum of \$1,250.00 in benefits
27 received by the insured per calendar year, to the extent not

1 covered by ~~medicare.~~ **MEDICARE.** The outpatient prescription drug
2 benefit may be included for sale or issuance in a ~~medicare~~
3 **MEDICARE** supplement policy until January 1, 2006.

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

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

23 (i) Preventive medical care benefit: Coverage for the
24 following preventive health services not covered by
25 ~~medicare.~~ **MEDICARE:**

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

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

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

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

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

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

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

26 (iv) Seven visits in any 1 week.

27 (v) Care furnished on a visiting basis in the insured's

1 home.

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

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

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

10 (k) New or innovative benefits: an insurer may, with the
11 prior approval of the ~~commissioner~~**DIRECTOR**, offer policies or
12 certificates with new or innovative benefits in addition to the
13 benefits provided in a policy or certificate that otherwise
14 complies with the applicable standards. The new or innovative
15 benefits may include benefits that are appropriate to ~~medicare~~
16 **MEDICARE** supplement insurance, new or innovative, not otherwise
17 available, cost-effective, and offered in a manner that is
18 consistent with the goal of simplification of ~~medicare~~**MEDICARE**
19 supplement policies. After December 31, 2005, the innovative
20 benefit ~~shall~~**MUST** not include an outpatient prescription drug
21 benefit.

22 (2) Reimbursement for the preventive screening tests and
23 services under subsection (1)(i)(ii) ~~shall~~**MUST** be for the actual
24 charges up to 100% of the ~~medicare-approved~~**MEDICARE-APPROVED**
25 amount for each test or service, as if ~~medicare~~**MEDICARE** were to
26 cover the test or service as identified in the American ~~medical~~
27 ~~association~~**MEDICAL ASSOCIATION** current procedural terminology

1 codes, to a maximum of \$120.00 annually under this benefit. This
 2 benefit ~~shall~~**DOES** not include payment for any procedure covered
 3 by ~~medicare~~**MEDICARE**.

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

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

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

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

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

22 (4) This section applies to ~~medicare~~**MEDICARE** supplement
 23 policies or certificates delivered or issued for delivery on or
 24 after June 2, 1992 with an effective date for coverage ~~prior to~~
 25 **BEFORE** June 1, 2010.

26 Sec. 3809a. (1) This section applies to all ~~medicare~~
 27 **MEDICARE** supplement policies or certificates delivered or issued

1 for delivery with an effective date for coverage on or after June
2 1, 2010.

3 (2) In addition to the basic core package of benefits
4 required under section 3807a, the following benefits may be
5 included in a ~~medicare~~**MEDICARE** supplement insurance policy and
6 if included shall ~~shall~~**MUST** conform to section ~~3811a(6)(b) to~~

7 ~~(j):~~**3811A(7) (B) TO (J) :**

8 (a) Medicare part A deductible: coverage for 100% of the
9 ~~medicare~~**MEDICARE** part A inpatient hospital deductible amount per
10 benefit period.

11 (b) Medicare part A deductible: coverage for 50% of the
12 ~~medicare~~**MEDICARE** part A inpatient hospital deductible amount per
13 benefit period.

14 (c) Skilled nursing facility care: coverage for the actual
15 billed charges up to the coinsurance amount from the twenty-first
16 day through the one hundredth day in a ~~medicare~~**MEDICARE** benefit
17 period for posthospital skilled nursing facility care eligible
18 under ~~medicare~~**MEDICARE** part A.

19 (d) Medicare part B deductible: coverage for 100% of the
20 ~~medicare~~**MEDICARE** part B deductible amount per calendar year
21 regardless of hospital confinement.

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

27 (f) Medically necessary emergency care in a foreign country:

1 coverage to the extent not covered by ~~medicare~~**MEDICARE** for 80%
2 of the billed charges for ~~medicare-eligible~~**MEDICARE-ELIGIBLE**
3 expenses for medically necessary emergency hospital, physician,
4 and medical care received in a foreign country, which care would
5 have been covered by ~~medicare~~**MEDICARE** if provided in the United
6 States and which care began during the first 60 consecutive days
7 of each trip outside the United States, subject to a calendar
8 year deductible of \$250.00, and a lifetime maximum benefit of
9 \$50,000.00. For purposes of this benefit, "emergency care" means
10 care needed immediately because of an injury or an illness of
11 sudden and unexpected onset.

12 Sec. 3811a. (1) This section applies to all ~~medicare~~
13 **MEDICARE** supplement policies or certificates delivered or issued
14 for delivery with an effective date for coverage on or after June
15 1, 2010. A policy or certificate ~~shall~~**MUST** not be advertised,
16 solicited, delivered, or issued for delivery in this state as a
17 ~~medicare~~**MEDICARE** supplement policy or certificate unless it
18 complies with these benefit standards. Benefit plan standards
19 applicable to ~~medicare~~**MEDICARE** supplement policies and
20 certificates issued before June 1, 2010 remain subject to the
21 requirements of section 3811.

22 (2) An insurer shall make available to each prospective
23 ~~medicare~~**MEDICARE** supplement policyholder and certificate holder
24 a policy form or certificate form containing only the basic core
25 benefits as provided in section 3807a. If an insurer makes
26 available any of the additional benefits described in section
27 3809a or offers standardized benefit plans K or L, the insurer

1 shall make available to each prospective ~~medicare~~**MEDICARE**
 2 supplement policyholder and certificate holder a policy form or
 3 certificate form containing either standardized benefit plan C or
 4 standardized benefit plan F.

5 **(3) BEGINNING JANUARY 1, 2020, AN INSURER IS NO LONGER**
 6 **REQUIRED TO OFFER STANDARDIZED BENEFIT PLAN C OR STANDARDIZED**
 7 **BENEFIT PLAN F. IF AN INSURER MAKES AVAILABLE ANY OF THE**
 8 **ADDITIONAL BENEFITS DESCRIBED IN SECTION 3809A, THE INSURER SHALL**
 9 **MAKE AVAILABLE TO EACH PROSPECTIVE MEDICARE SUPPLEMENT**
 10 **POLICYHOLDER AND CERTIFICATE HOLDER A POLICY FORM OR CERTIFICATE**
 11 **FORM THAT CONTAINS EITHER STANDARDIZED BENEFIT PLAN D OR**
 12 **STANDARDIZED BENEFIT PLAN G.**

13 **(4)** ~~(3)~~ Groups, packages, or combinations of ~~medicare~~
 14 **MEDICARE** supplement benefits other than those listed in this
 15 section ~~shall~~**MUST** not be offered for sale in this state except
 16 as may be permitted in subsection ~~(6)(k)~~**(7) (K)**.

17 **(5)** ~~(4)~~ Benefit plans ~~shall~~**MUST** be uniform in structure,
 18 language, designation, and format to the standard benefit plans
 19 in subsection ~~(6)~~**(7)** and ~~shall~~**MUST** conform to the definitions
 20 in this chapter. Each benefit ~~shall~~**MUST** be structured in
 21 accordance with sections 3807a and 3809a and list the benefits in
 22 the order shown in subsection ~~(6)~~**(7)**. ~~For purposes of (7)~~. **AS USED**
 23 **IN** this section, "structure, language, **DESIGNATION**, and format"
 24 means style, arrangement, and overall content of a benefit.

25 **(6)** ~~(5)~~ In addition to the benefit plan designations as
 26 provided under subsection ~~(6)~~**(7)**, an insurer may use other
 27 designations to the extent permitted by law.

(7) ~~(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). **BEGINNING JANUARY 1, 2020, THE STANDARDIZED BENEFIT PLANS DESCRIBED IN SECTION 3811B MAY BE OFFERED TO ANY INDIVIDUAL WHO WAS ELIGIBLE FOR MEDICARE BEFORE JANUARY 1, 2020.**

(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). **BEGINNING JANUARY 1, 2020, THE STANDARDIZED BENEFIT PLANS DESCRIBED IN SECTION 3811B MAY BE OFFERED TO ANY INDIVIDUAL WHO WAS ELIGIBLE**

1 **FOR MEDICARE BEFORE JANUARY 1, 2020.**

2 (e) A standardized ~~medicare~~**MEDICARE** supplement benefit plan
 3 F ~~shall~~**MUST** include only the following: the core benefits as
 4 ~~defined in~~**REQUIRED UNDER** section 3807a ~~, and~~**AND** 100% of the
 5 ~~medicare~~**MEDICARE** part A deductible, skilled nursing facility
 6 care, 100% of the ~~medicare~~**MEDICARE** part B deductible, 100% of
 7 the ~~medicare~~**MEDICARE** part B excess charges, and medically
 8 necessary emergency care in a foreign country as defined in
 9 section 3809a(2)(a), (c), (d), (e), and (f). A standardized
 10 ~~medicare~~**MEDICARE** supplement plan F high deductible ~~shall~~**MUST**
 11 include only the following: 100% of covered expenses following
 12 the payment of the annual ~~high deductible~~**HIGH-DEDUCTIBLE** plan F
 13 deductible. The covered expenses include the core benefits as
 14 ~~defined in~~**REQUIRED UNDER** section 3807a ~~, plus~~**AND** 100% of the
 15 ~~medicare~~**MEDICARE** part A deductible, skilled nursing facility
 16 care, 100% of the ~~medicare~~**MEDICARE** part B deductible, 100% of
 17 the ~~medicare~~**MEDICARE** part B excess charges, and medically
 18 necessary emergency care in a foreign country as defined in
 19 section 3809a(2)(a), (c), (d), (e), and (f). The annual ~~high~~
 20 ~~deductible~~**HIGH-DEDUCTIBLE** plan F deductible ~~shall~~**MUST** consist
 21 of out-of-pocket expenses, other than premiums, for services
 22 covered by the ~~medicare~~**MEDICARE** supplement plan F policy, and
 23 ~~shall~~**MUST** be in addition to any other specific benefit
 24 deductibles. The annual ~~high deductible~~**HIGH-DEDUCTIBLE** plan F
 25 deductible is \$1,500.00 for calendar year 1999, and the secretary
 26 shall adjust it annually thereafter to reflect the change in the
 27 ~~consumer price index~~**CONSUMER PRICE INDEX** for all urban consumers

1 for the 12-month period ending with August of the preceding year,
 2 rounded to the nearest multiple of \$10.00. **BEGINNING JANUARY 1,**
 3 **2020, THE STANDARDIZED BENEFIT PLANS DESCRIBED IN SECTION 3811B**
 4 **MAY BE OFFERED TO ANY INDIVIDUAL WHO WAS ELIGIBLE FOR MEDICARE**
 5 **BEFORE JANUARY 1, 2020.**

6 (f) A standardized ~~medicare~~**MEDICARE** supplement benefit plan
 7 ~~G shall~~**MUST** include only the following: the core benefits as
 8 ~~defined in~~**REQUIRED UNDER** section 3807a ~~, AND~~ 100% of the
 9 ~~medicare~~**MEDICARE** part A deductible, skilled nursing facility
 10 care, 100% of the ~~medicare~~**MEDICARE** part B excess charges, and
 11 medically necessary emergency care in a foreign country as
 12 defined in section 3809a(2)(a), (c), (e), and (f). **BEGINNING**
 13 **JANUARY 1, 2020, THE STANDARDIZED BENEFIT PLANS DESCRIBED IN**
 14 **SECTION 3811B MAY BE OFFERED TO ANY INDIVIDUAL WHO WAS ELIGIBLE**
 15 **FOR MEDICARE BEFORE JANUARY 1, 2020.**

16 (g) Standardized ~~medicare~~**MEDICARE** supplement benefit plan K
 17 ~~shall~~**MUST** consist of the following:

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

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

25 (iii) ~~Upon~~**ON** exhaustion of the ~~medicare~~**MEDICARE** hospital
 26 inpatient coverage, including the lifetime reserve days, coverage
 27 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

1 under ~~medicare~~**MEDICARE** part B after the policyholder pays the
 2 part B deductible until the out-of-pocket limitation is met as
 3 described in subparagraph (x) .

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

7 (x) Coverage of 100% of all cost sharing under ~~medicare~~
 8 **MEDICARE** parts A and B for the balance of the calendar year after
 9 the individual has reached the out-of-pocket limitation on annual
 10 expenditures under ~~medicare~~**MEDICARE** parts A and B of \$4,000.00
 11 in 2006, indexed each year by the appropriate inflation
 12 adjustment specified by the secretary of the United States
 13 ~~department of health and human services.~~**DEPARTMENT OF HEALTH AND**
 14 **HUMAN SERVICES.**

15 (h) Standardized ~~medicare~~**MEDICARE** supplement benefit plan L
 16 ~~shall~~**MUST** consist of the following:

17 (i) The benefits described in subdivision (g) (i) , (ii) , (iii) ,
 18 and (ix) .

19 (ii) The benefits described in subdivision (g) (iv) , (v) , (vi) ,
 20 (vii) , and (viii) , but substituting 75% for 50%.

21 (iii) The benefit described in subdivision (g) (x) , but
 22 substituting \$2,000.00 for \$4,000.00.

23 (i) A standardized ~~medicare~~**MEDICARE** supplement benefit plan
 24 M ~~shall~~**MUST** include only the following: the core benefits as
 25 ~~defined in~~**REQUIRED UNDER** section 3807a and 50% of the ~~medicare~~
 26 **MEDICARE** part A deductible, skilled nursing care, and medically
 27 necessary emergency care in a foreign country as defined in

1 section 3809a(2)(b), (c), and (f).

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

9 (i) The lesser of \$20.00 or the ~~medicare~~**MEDICARE** part B
 10 coinsurance or copayment for each covered health care provider
 11 office visit, including visits to medical specialists.

12 (ii) The lesser of \$50.00 or the ~~medicare~~**MEDICARE** part B
 13 coinsurance or copayment for each covered emergency room visit.
 14 The copayment ~~shall~~**MUST** be waived if the insured is admitted to
 15 any hospital and the emergency visit is subsequently covered as a
 16 ~~medicare~~**MEDICARE** part A expense.

17 (k) New or innovative benefits: an insurer may, with the
 18 prior approval of the ~~commissioner~~**DIRECTOR**, offer policies or
 19 certificates with new or innovative benefits in addition to the
 20 benefits provided in a policy or certificate that otherwise
 21 complies with the applicable standards. The new or innovative
 22 benefits may include benefits that are appropriate to ~~medicare~~
 23 **MEDICARE** supplement insurance, new or innovative, not otherwise
 24 available, cost-effective, and offered in a manner that is
 25 consistent with the goal of simplification of ~~medicare~~**MEDICARE**
 26 supplement policies. The innovative benefit ~~shall~~**MUST** not
 27 include an outpatient prescription drug benefit. New or

1 innovative benefits ~~shall~~**MUST** not be used to change or reduce
2 benefits, including a change of any cost-sharing provision, in
3 any standardized plan.

4 **SEC. 3811B. (1) BENEFIT PLAN STANDARDS APPLICABLE TO**
5 **MEDICARE SUPPLEMENT POLICIES AND CERTIFICATES ISSUED TO**
6 **INDIVIDUALS ELIGIBLE BEFORE JANUARY 1, 2020 REMAIN SUBJECT TO THE**
7 **REQUIREMENTS OF SECTION 3811 OR 3811A, AS APPLICABLE.**

8 **(2) THIS SECTION APPLIES TO ALL MEDICARE SUPPLEMENT POLICIES**
9 **OR CERTIFICATES DELIVERED OR ISSUED FOR DELIVERY TO INDIVIDUALS**
10 **NEWLY ELIGIBLE FOR MEDICARE ON OR AFTER JANUARY 1, 2020 BECAUSE**
11 **OF EITHER OF THE FOLLOWING:**

12 **(A) BY REASON OF ATTAINING AGE 65 ON OR AFTER JANUARY 1,**
13 **2020.**

14 **(B) BY REASON OF ENTITLEMENT TO BENEFITS UNDER PART A**
15 **PURSUANT TO SECTION 226(A) OR (B) OF THE SOCIAL SECURITY ACT, 42**
16 **USC 426, OR WHO IS DEEMED TO BE ELIGIBLE FOR BENEFITS UNDER**
17 **SECTION 226(A) OF THE SOCIAL SECURITY ACT, 42 USC 426, ON OR**
18 **AFTER JANUARY 1, 2020.**

19 **(3) THE STANDARDS AND REQUIREMENTS OF SECTION 3811 OR 3811A,**
20 **AS APPLICABLE, APPLY TO ALL MEDICARE SUPPLEMENT POLICIES OR**
21 **CERTIFICATES DELIVERED OR ISSUED FOR DELIVERY TO INDIVIDUALS**
22 **NEWLY ELIGIBLE FOR MEDICARE ON OR AFTER JANUARY 1, 2020, WITH THE**
23 **FOLLOWING EXCEPTIONS:**

24 **(A) STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN C IS**
25 **REDESIGNATED AS PLAN D AND MUST PROVIDE THE BENEFITS CONTAINED IN**
26 **SECTION 3811(5)(C) OR 3811A(7)(C), AS APPLICABLE, BUT MUST NOT**
27 **PROVIDE COVERAGE FOR ANY PORTION OF THE MEDICARE PART B**

1 DEDUCTIBLE.

2 (B) STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN F IS
3 REDESIGNATED AS PLAN G AND MUST PROVIDE THE BENEFITS CONTAINED IN
4 SECTION 3811(5) (F) OR 3811A(7) (E), AS APPLICABLE, BUT MUST NOT
5 PROVIDE COVERAGE FOR ANY PORTION OF THE MEDICARE PART B
6 DEDUCTIBLE.

7 (C) STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLANS C, F, AND
8 F WITH HIGH DEDUCTIBLE MAY NOT BE OFFERED TO INDIVIDUALS NEWLY
9 ELIGIBLE FOR MEDICARE ON OR AFTER JANUARY 1, 2020.

10 (D) STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN F WITH
11 HIGH DEDUCTIBLE IS REDESIGNATED AS PLAN G WITH HIGH DEDUCTIBLE
12 AND MUST PROVIDE THE BENEFITS CONTAINED IN SECTION 3811(5) (F) OR
13 3811A(7) (E), AS APPLICABLE, BUT MUST NOT PROVIDE COVERAGE FOR ANY
14 PORTION OF THE MEDICARE PART B DEDUCTIBLE. HOWEVER, THE MEDICARE
15 PART B DEDUCTIBLE PAID BY THE BENEFICIARY MUST BE CONSIDERED AN
16 OUT-OF-POCKET EXPENSE IN MEETING THE ANNUAL HIGH-DEDUCTIBLE.

17 (E) THE REFERENCE TO PLANS C OR F CONTAINED IN SECTION
18 3811A(2) IS DEEMED A REFERENCE TO PLANS D OR G FOR PURPOSES OF
19 THIS SECTION.

20 (4) A POLICY OR CERTIFICATE MUST NOT PROVIDE COVERAGE OF THE
21 MEDICARE PART B DEDUCTIBLE AND MAY NOT BE ADVERTISED, SOLICITED,
22 DELIVERED, OR ISSUED FOR DELIVERY IN THIS STATE AS A MEDICARE
23 SUPPLEMENT POLICY OR CERTIFICATE UNLESS IT COMPLIES WITH THE
24 BENEFIT STANDARDS OUTLINED IN THIS SECTION.

25 (5) ON OR AFTER JANUARY 1, 2020, THE STANDARDIZED BENEFIT
26 PLANS DESCRIBED IN THIS SECTION MAY BE OFFERED TO ANY INDIVIDUAL
27 WHO WAS ELIGIBLE FOR MEDICARE BEFORE JANUARY 1, 2020.

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

17 Sec. 3815. (1) An insurer that offers a ~~medicare~~**MEDICARE**
18 supplement policy shall provide to the applicant at the time of
19 application an outline of coverage **IN WRITTEN OR ELECTRONIC**
20 **FORMAT** and, except for direct response solicitation policies,
21 shall obtain an acknowledgment of receipt of the outline of
22 coverage from the applicant **IN WRITTEN OR ELECTRONIC FORMAT**. The
23 outline of coverage provided to applicants ~~pursuant to~~**UNDER** this
24 section ~~shall~~**MUST** consist of the following 4 parts:

- 25 (a) A cover page.
26 (b) Premium information.
27 (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

1 payment mode ~~shall~~ **MUST** be stated for all plans that are offered
 2 to the applicant. All possible premiums for the applicant ~~shall~~
 3 **MUST** be illustrated. The following items ~~shall~~ **MUST** be included
 4 in the outline of coverage in the order prescribed below and in
 5 substantially the following form, as approved by the
 6 ~~commissioner~~: **DIRECTOR**:

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

9 This chart shows the benefits included in each of the
 10 standard Medicare supplement plans. Every company must make Plan
 11 "A" available. Some plans may not be available in your state.

12 Plans E, H, I, and J are no longer available for sale. (This
 13 sentence ~~shall~~ **MUST** not appear after June 1, 2011.)

14 **BASIC BENEFITS:**

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

17 Medical Expenses: Part B coinsurance (generally 20% of
 18 Medicare-approved expenses) or copayments for hospital
 19 outpatient services. Plans K, L, and N require insureds
 20 to pay a portion of Part B coinsurance or copayments.

21 Blood: First three pints of blood each year.

22 Hospice: Part A coinsurance

23	A	B	C**	D	F F* **	G/G*
24	Basic,	Basic,	Basic,	Basic,	Basic,	Basic,

1	including	including	including	including	including	including
2	100% Part	100% Part	100% Part	100% Part	100% Part	100% Part
3	B coin-	B coinsur-	B coinsur-	B coinsur-	B coinsur-	B coinsur-
4	surance	ance	ance	ance	ance	ance
5			Skilled	Skilled	Skilled	Skilled
6			Nursing	Nursing	Nursing	Nursing
7			Facility	Facility	Facility	Facility
8			Coinsur-	Coinsur-	Coinsur-	Coinsur-
9			ance	ance	ance	ance
10		Part A	Part A	Part A	Part A	Part A
11		Deductible	Deductible	Deductible	Deductible	Deductible
12			Part B		Part B	
13			Deductible		Deductible	
14					Part B	Part B
15					Excess	Excess
16					(100%)	(100%)
17			Foreign	Foreign	Foreign	Foreign
18			Travel	Travel	Travel	Travel
19			Emergency	Emergency	Emergency	Emergency

20

21	K	L	M	N
22	Hospitalization	Hospitalization	Basic,	Basic, includ-
23	and preventive	and preventive	including 100%	ing 100% Part B
24	care paid at	care paid at	Part B	coinsurance,
25	100%; other	100%; other	coinsurance	except up to
26	basic benefits	basic benefits		\$20 copayment
27	paid at 50%	paid at 75%		for office

1				visit, and up
2				to \$50 copay-
3				ment for ER
4	50% Skilled	75% Skilled	Skilled	Skilled
5	Nursing	Nursing	Nursing	Nursing
6	Facility	Facility	Facility	Facility
7	Coinsurance	Coinsurance	Coinsurance	Coinsurance
8	50% Part A	75% Part A	50% Part A	Part A
9	Deductible	Deductible	Deductible	Deductible
10				
11				
12			Foreign	Foreign
13			Travel	Travel
14			Emergency	Emergency
15	Out-of-pocket	Out-of-pocket		
16	limit \$4,140;	limit \$2,070;		
17	paid at 100%	paid at 100%		
18	after limit	after limit		
19	reached	reached		

20 * ~~Plan~~ **PLANS F AND G** also ~~has an option~~ **HAVE OPTIONS** called
 21 a ~~high-deductible Plan F~~ **— This — AND HIGH-DEDUCTIBLE PLAN G. THESE**
 22 ~~high-deductible plan pays~~ **PLANS PAY** the same benefits as Plan F
 23 **OR PLAN G, AS APPLICABLE,** after one has paid a calendar year
 24 ~~\$1,860—\$2,180~~ deductible. Benefits from high-deductible Plan F **OR**
 25 **HIGH-DEDUCTIBLE PLAN G** will not begin until out-of-pocket
 26 expenses exceed ~~\$1,860—\$2,180~~. Out-of-pocket expenses for ~~this~~
 27 ~~deductible~~ **THESE DEDUCTIBLES** are expenses that would ordinarily
 28 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

1 must read the policy itself to understand all of the rights and
2 duties of both you and your insurance company.

3 RIGHT TO RETURN POLICY

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

9 POLICY REPLACEMENT

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

13 NOTICE

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

15 [For agent issued policies]

16 Neither (insert insurer's name) nor its agents are connected
17 with ~~medicare~~. **MEDICARE**.

18 [For direct response issued policies]

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

21 This outline of coverage does not give all the details of
22 ~~medicare~~ **MEDICARE** coverage. Contact your local social security
23 office or consult ~~"the medicare handbook"~~ **"THE MEDICARE HANDBOOK"**

1 for more details.

2 COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

22 PLAN A

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

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

1 service as an inpatient in a hospital and ends after you have
 2 been out of the hospital and have not received skilled care in
 3 any other facility for 60 days in a row.

4	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
5	HOSPITALIZATION*			
6	Semiprivate room and			
7	board, general nursing			
8	and miscellaneous			
9	services and supplies			
10	First 60 days	All but	\$0	\$992
11		\$992		(Part A
12				Deductible)
13	61st thru 90th day	All but	\$248	\$0
14		\$248 a day	a day	
15	91st day and after:			
16	-While using 60			
17	lifetime reserve days	All but	\$496	\$0
18		\$496 a day	a day	
19	-Once lifetime reserve			
20	days are used:			
21	-Additional 365 days	\$0	100% of	\$0**
22			Medicare	
23			Eligible	
24			Expenses	
25	-Beyond the			
26	Additional 365 days	\$0	\$0	All Costs
27	SKILLED NURSING FACILITY			

1	CARE*			
2	You must meet Medicare's			
3	requirements, including			
4	having been in a hospital			
5	for at least 3 days and			
6	entered a Medicare-			
7	approved facility within			
8	30 days after leaving the			
9	hospital			
10	First 20 days	All approved		
11		amounts	\$0	\$0
12	21st thru 100th day	All but	\$0	Up to
13		\$124 a day		\$124 a day
14	101st day and after	\$0	\$0	All costs
15	BLOOD			
16	First 3 pints	\$0	3 pints	\$0
17	Additional amounts	100%	\$0	\$0
18	HOSPICE CARE			
19	You must meet	All but very		\$0
20	Medicare's requirements	limited	Medicare	
21	including a doctor's	copayment/	copayment/	
22	certification of terminal	coinsurance	coinsurance	
23	illness	for outpatient		
24		drugs and		
25		inpatient		
26		respite care		
27				

28 **NOTICE: When your Medicare Part A hospital benefits are

1 exhausted, the insurer stands in the place of Medicare and will
 2 pay whatever amount Medicare would have paid for up to an
 3 additional 365 days as provided in the policy's "Core Benefits."
 4 During this time the hospital is prohibited from billing you for
 5 the balance based on any difference between its billed charges
 6 and the amount Medicare would have paid.

7 PLAN A

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

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

12	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
13	MEDICAL EXPENSES—			
14	In or out of the hospital			
15	and outpatient hospital			
16	treatment, such as			
17	Physician's services,			
18	inpatient and outpatient			
19	medical and surgical			
20	services and supplies,			
21	physical and speech			
22	therapy, diagnostic			
23	tests, durable medical			
24	equipment,			
25	First \$131 of			
26	Medicare Approved	\$0	\$0	\$131

1	Amounts*			(Part B
2				Deductible)
3	Remainder of Medicare			
4	Approved Amounts	80%	20%	\$0
5	Part B Excess Charges			
6	(Above Medicare			
7	Approved Amounts)	\$0	\$0	All Costs
8	BLOOD			
9	First 3 pints	\$0	All Costs	\$0
10	Next \$131 of			
11	Medicare	\$0	\$0	\$131
12	Approved Amounts*			(Part B
13				Deductible)
14	Remainder of Medicare			
15	Approved Amounts	80%	20%	\$0
16	CLINICAL LABORATORY			
17	SERVICES—			
18	Tests for			
19	diagnostic services	100%	\$0	\$0

20 PARTS A & B

21	HOME HEALTH CARE			
22	Medicare Approved			
23	Services			
24	—Medically necessary			
25	skilled care services			
26	and medical supplies	100%	\$0	\$0

1	-Durable medical			
2	equipment			
3	First \$131 of			
4	Medicare	\$0	\$0	\$131
5	Approved Amounts*			(Part B
6				Deductible)
7	Remainder of Medicare			
8	Approved Amounts	80%	20%	\$0

9

PLAN B

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

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

15	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
16	HOSPITALIZATION*			
17	Semiprivate room and			
18	board, general nursing			
19	and miscellaneous			
20	services and supplies			
21	First 60 days	All but	\$992	\$0
22		\$992	(Part A	
23			Deductible)	
24	61st thru 90th day	All but	\$248	\$0
25		\$248 a day	a day	

1	91st day and after			
2	-While using 60			
3	lifetime reserve days	All but	\$496	\$0
4		\$496 a day	a day	
5	-Once lifetime reserve			
6	days are used:			
7	-Additional 365 days	\$0	100% of	\$0**
8			Medicare	
9			Eligible	
10			Expenses	
11	-Beyond the			
12	Additional 365 days	\$0	\$0	All Costs
13	SKILLED NURSING FACILITY			
14	CARE*			
15	You must meet Medicare's			
16	requirements, including			
17	having been in a hospital			
18	for at least 3 days and			
19	entered a Medicare-			
20	approved facility within			
21	30 days after leaving the			
22	hospital			
23	First 20 days	All approved		
24		amounts	\$0	\$0
25	21st thru 100th day	All but	\$0	Up to
26		\$124 a day		\$124 a day
27	101st day and after	\$0	\$0	All costs
28	BLOOD			
29	First 3 pints	\$0	3 pints	\$0

1	Additional amounts	100%	\$0	\$0
2	HOSPICE CARE			
3		All but very		
4		limited	Medicare	\$0
5		copayment/	copayment/	
6		coinsurance	coinsurance	
7	You must meet	for outpatient		
8	Medicare's requirements,	drugs and		
9	including a doctor's	inpatient		
10	certification of	respite care		
11	terminal illness			

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

19 PLAN B

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

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

24	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
-----------	----------	---------------	-----------	---------

1	MEDICAL EXPENSES—			
2	In or out of the hospital			
3	and outpatient hospital			
4	treatment, such as			
5	Physician's services,			
6	inpatient and outpatient			
7	medical and surgical			
8	services and supplies,			
9	physical and speech			
10	therapy, diagnostic			
11	tests, durable medical			
12	equipment,			
13	First \$131 of			
14	Medicare Approved	\$0	\$0	\$131
15	Amounts*			(Part B
16				Deductible)
17	Remainder of Medicare			
18	Approved Amounts	80%	20%	\$0
19	Part B Excess Charges			
20	(Above Medicare			
21	Approved Amounts)	\$0	\$0	All Costs
22	BLOOD			
23	First 3 pints	\$0	All Costs	\$0
24	Next \$131 of Medicare			
25	Approved Amounts*	\$0	\$0	\$131
26				(Part B
27	Remainder of Medicare			Deductible)
28	Approved Amounts	80%	20%	\$0
29	CLINICAL LABORATORY			

1	SERVICES—			
2	Tests for			
3	diagnostic services	100%	\$0	\$0

4

PARTS A & B

5	HOME HEALTH CARE			
6	Medicare Approved			
7	Services			
8	—Medically necessary			
9	skilled care services			
10	and medical supplies	100%	\$0	\$0
11	—Durable medical			
12	equipment			
13	First \$131 of			
14	Medicare			
15	Approved Amounts*	\$0	\$0	\$131
16				(Part B
17				Deductible)
18	Remainder of Medicare			
19	Approved Amounts	80%	20%	\$0

20

PLAN C

21

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

22

*A benefit period begins on the first day you receive

23

service as an inpatient in a hospital and ends after you have

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

3	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
4	HOSPITALIZATION*			
5	Semiprivate room and			
6	board, general nursing			
7	and miscellaneous			
8	services and supplies			
9	First 60 days	All but	\$992	\$0
10		\$992	(Part A	
11			Deductible)	
12	61st thru 90th day	All but	\$248	\$0
13		\$248 a day	a day	
14	91st day and after			
15	—While using 60			
16	lifetime reserve days	All but	\$496	\$0
17		\$496 a day	a day	
18	—Once lifetime reserve			
19	days are used:			
20	—Additional 365 days	\$0	100% of	\$0**
21			Medicare	
22			Eligible	
23			Expenses	
24	—Beyond the			
25	Additional 365 days	\$0	\$0	All Costs
26	SKILLED NURSING FACILITY			
27	CARE*			
28	You must meet Medicare's			

1	requirements, including			
2	having been in a hospital			
3	for at least 3 days and			
4	entered a Medicare-			
5	approved facility within			
6	30 days after leaving the			
7	hospital			
8	First 20 days	All approved		
9		amounts	\$0	\$0
10	21st thru 100th day	All but	Up to	\$0
11		\$124 a day	\$124 a day	
12	101st day and after	\$0	\$0	All costs
13	BLOOD			
14	First 3 pints	\$0	3 pints	\$0
15	Additional amounts	100%	\$0	\$0
16	HOSPICE CARE			
17		All but very		\$0
18		limited	Medicare	
19		copayment/	copayment/	
20		coinsurance	coinsurance	
21	You must meet	for outpatient		
22	Medicare's requirements,	drugs and		
23	including a doctor's	inpatient		
24	certification of	respite care		
25	terminal illness			

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

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

5 PLAN C

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

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

10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
11	MEDICAL EXPENSES—			
12	In or out of the hospital			
13	and outpatient hospital			
14	treatment, such as			
15	Physician's services,			
16	inpatient and outpatient			
17	medical and surgical			
18	services and supplies,			
19	physical and speech			
20	therapy, diagnostic			
21	tests, durable medical			
22	equipment,			
23	First \$131 of			
24	Medicare Approved	\$0	\$131	\$0
25	Amounts*		(Part B	
26			Deductible)	

1	Remainder of Medicare			
2	Approved Amounts	80%	20%	\$0
3	Part B Excess Charges			
4	(Above Medicare			
5	Approved Amounts)	\$0	\$0	All Costs
6	BLOOD			
7	First 3 pints	\$0	All Costs	\$0
8	Next \$131 of Medicare			
9	Approved Amounts*	\$0	\$131	\$0
10			(Part B	
11			Deductible)	
12	Remainder of Medicare			
13	Approved Amounts	80%	20%	\$0
14	CLINICAL LABORATORY			
15	SERVICES—			
16	Tests for			
17	diagnostic services	100%	\$0	\$0

18 PARTS A & B

19	HOME HEALTH CARE			
20	Medicare Approved			
21	Services			
22	—Medically necessary			
23	skilled care services			
24	and medical supplies	100%	\$0	\$0
25	—Durable medical			
26	equipment			

1	First \$131 of			
2	Medicare Approved	\$0	\$131	\$0
3	Amounts*		(Part B	
4			Deductible)	
5	Remainder of Medicare			
6	Approved Amounts	80%	20%	\$0

7 OTHER BENEFITS—NOT COVERED BY MEDICARE

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

23 PLAN D

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

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

5	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
6	HOSPITALIZATION*			
7	Semiprivate room and			
8	board, general nursing			
9	and miscellaneous			
10	services and supplies			
11	First 60 days	All but	\$992	\$0
12		\$992	(Part A	
13			Deductible)	
14	61st thru 90th day	All but	\$248	\$0
15		\$248 a day	a day	
16	91st day and after			
17	—While using 60			
18	lifetime reserve days	All but	\$496	\$0
19		\$496 a day	a day	
20	—Once lifetime reserve			
21	days are used:			
22	—Additional 365 days	\$0	100% of	\$0**
23			Medicare	
24			Eligible	
25			Expenses	
26	—Beyond the			
27	Additional 365 days	\$0	\$0	All Costs

1	SKILLED NURSING FACILITY			
2	CARE*			
3	You must meet Medicare's			
4	requirements, including			
5	having been in a hospital			
6	for at least 3 days and			
7	entered a Medicare-			
8	approved facility within			
9	30 days after leaving the			
10	hospital			
11	First 20 days	All approved		
12		amounts	\$0	\$0
13	21st thru 100th day	All but	Up to	\$0
14		\$124 a day	\$124 a day	
15	101st day and after	\$0	\$0	All costs
16	BLOOD			
17	First 3 pints	\$0	3 pints	\$0
18	Additional amounts	100%	\$0	\$0
19	HOSPICE CARE			
20		All but very	Medicare	\$0
21		limited	copayment/	
22		copayment/	coinsurance	
23		coinsurance		
24	You must meet	for outpatient		
25	Medicare's requirements,	drugs and		
26	including a doctor's	inpatient		
27	certification of	respite care		
28	terminal illness			

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

8 PLAN D

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

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

13	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
14	MEDICAL EXPENSES—			
15	In or out of the hospital			
16	and outpatient hospital			
17	treatment, such as			
18	Physician's services,			
19	inpatient and outpatient			
20	medical and surgical			
21	services and supplies,			
22	physical and speech			
23	therapy, diagnostic			
24	tests, durable medical			
25	equipment,			
26	First \$131 of			

1	Medicare Approved	\$0	\$0	\$131
2	Amounts*			(Part B
3				Deductible)
4	Remainder of Medicare			
5	Approved Amounts	80%	20%	\$0
6	Part B Excess Charges			
7	(Above Medicare			
8	Approved Amounts)	\$0	\$0	All Costs
9	BLOOD			
10	First 3 pints	\$0	All Costs	\$0
11	Next \$131 of Medicare			
12	Approved Amounts*	\$0	\$0	\$131
13				(Part B
14				Deductible)
15	Remainder of Medicare			
16	Approved Amounts	80%	20%	\$0
17	CLINICAL LABORATORY			
18	SERVICES—			
19	Tests for			
20	diagnostic services	100%	\$0	\$0

21

PARTS A & B

22	HOME HEALTH CARE			
23	Medicare Approved			
24	Services			
25	—Medically necessary			
26	skilled care services			

1	and medical supplies	100%	\$0	\$0
2	-Durable medical			
3	equipment			
4	First \$131 of			
5	Medicare Approved	\$0	\$0	\$131
6	Amounts*			(Part B
7				Deductible)
8	Remainder of Medicare			
9	Approved Amounts	80%	20%	\$0

10 OTHER BENEFITS—NOT COVERED BY MEDICARE

11	FOREIGN TRAVEL—			
12	Not covered by Medicare			
13	Medically necessary			
14	emergency care services			
15	beginning during the			
16	first 60 days of each			
17	trip outside the USA			
18	First \$250 each			
19	calendar year	\$0	\$0	\$250
20	Remainder of charges	\$0	80% to a	20% and
21			lifetime	amounts
22			maximum	over the
23			benefit	\$50,000
24			of \$50,000	lifetime
25				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)~~ **\$1,860** deductible. Benefits from the ~~high deductible~~ **HIGH-DEDUCTIBLE** plan F will not begin until out-of-pocket expenses are \$1,860. 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 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$1,860 DEDUCTIBLE**, YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$992	\$992 (Part A	\$0

1			Deductible)	
2	61st thru 90th day	All but	\$248	\$0
3		\$248 a day	a day	
4	91st day and after			
5	-While using 60			
6	lifetime reserve days	All but	\$496	\$0
7		\$496 a day	a day	
8	-Once lifetime reserve			
9	days are used:			
10	-Additional 365 days	\$0	100% of	\$0***
11			Medicare	
12			Eligible	
13			Expenses	
14	-Beyond the			
15	Additional 365 days	\$0	\$0	All Costs
16	SKILLED NURSING FACILITY			
17	CARE*			
18	You must meet Medicare's			
19	requirements, including			
20	having been in a			
21	hospital for at least			
22	3 days and entered a			
23	Medicare-approved			
24	facility within 30 days			
25	after leaving the			
26	hospital			
27	First 20 days	All approved		
28		amounts	\$0	\$0
29	21st thru 100th day	All but	Up to	\$0

1		\$124 a day	\$124 a day	
2	101st day and after	\$0	\$0	All costs
3	BLOOD			
4	First 3 pints	\$0	3 pints	\$0
5	Additional amounts	100%	\$0	\$0
6	HOSPICE CARE			
7		All but very	Medicare	\$0
8		limited	copayment/	
9		copayment/	coinsurance	
10		coinsurance		
11	You must	for		
12	meet Medicare's	outpatient		
13	requirements, including	drugs and		
14	a doctor's certification	inpatient		
15	of terminal illness	respite care		

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

23 PLAN F

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

25 *Once you have been billed \$131 of Medicare-Approved amounts
26 for covered services (which are noted with an asterisk), your

1 Part B Deductible will have been met for the calendar year.
 2 **This ~~high deductible~~ **HIGH-DEDUCTIBLE** plan pays the same
 3 benefits as plan F after you have paid a calendar year ~~(\$1,860)~~
 4 **\$1,860** deductible. Benefits from the ~~high deductible~~ **HIGH-**
 5 **DEDUCTIBLE** plan F will not begin until out-of-pocket expenses are
 6 \$1,860. Out-of-pocket expenses for this deductible are expenses
 7 that would ordinarily be paid by the policy. This includes
 8 ~~medicare~~ **MEDICARE** deductibles for part A and part B, but does not
 9 include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$1,860 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$1,860 DEDUCTIBLE**, YOU PAY
15 MEDICAL EXPENSES— 16 In or out of the hospital 17 and outpatient hospital 18 treatment, such as 19 Physician's services, 20 inpatient and outpatient 21 medical and surgical 22 services and supplies, 23 physical and speech 24 therapy, diagnostic 25 tests, durable medical 26 equipment, 27 First \$131 of 28 Medicare Approved	\$0	\$131	\$0

1	Amounts*		(Part B	
2			Deductible)	
3	Remainder of Medicare			
4	Approved Amounts	80%	20%	\$0
5	Part B Excess Charges			
6	(Above Medicare			
7	Approved Amounts)	\$0	100%	\$0
8	BLOOD			
9	First 3 pints	\$0	All Costs	\$0
10	Next \$131 of			
11	Medicare Approved	\$0	\$131	\$0
12	Amounts*		(Part B	
13			Deductible)	
14	Remainder of Medicare			
15	Approved Amounts	80%	20%	\$0
16	CLINICAL LABORATORY			
17	SERVICES—			
18	Tests for			
19	diagnostic services	100%	\$0	\$0

20

PARTS A & B

21	HOME HEALTH CARE			
22	Medicare Approved			
23	Services			
24	—Medically necessary			
25	skilled care services			
26	and medical supplies	100%	\$0	\$0

1	-Durable medical			
2	equipment			
3	First \$131 of			
4	Medicare Approved	\$0	\$131	\$0
5	Amounts*		(Part B	
6			Deductible)	
7	Remainder of Medicare			
8	Approved Amounts	80%	20%	\$0

9 OTHER BENEFITS—NOT COVERED BY MEDICARE

10	FOREIGN TRAVEL—			
11	Not covered by Medicare			
12	Medically necessary			
13	emergency care services			
14	beginning during the			
15	first 60 days of each			
16	trip outside the USA			
17	First \$250 each			
18	calendar year	\$0	\$0	\$250
19	Remainder of charges	\$0	80% to a	20% and
20			lifetime	amounts
21			maximum	over the
22			benefit	\$50,000
23			of \$50,000	lifetime
24				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 \$2,180 DEDUCTIBLE. BENEFITS FROM THE HIGH-DEDUCTIBLE PLAN G WILL NOT BEGIN UNTIL OUT-OF-POCKET EXPENSES ARE \$2,180. 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 \$2,180 DEDUCTIBLE, **	IN ADDITION TO \$2,180 DEDUCTIBLE, **
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			

1	First 60 days	All but	\$992 \$1,288	\$0
2		\$992 \$1,288	(Part A	
3			Deductible)	
4	61st thru 90th day	All but	\$248 \$322	\$0
5		\$248 \$322 a day	a day	
6	91st day and after			
7	-While using 60			
8	lifetime reserve days	All but	\$496 \$644	\$0
9		\$496 \$644 a day	a day	
10	-Once lifetime reserve			
11	days are used:			
12	-Additional 365 days	\$0	100% of	\$0***
13			Medicare	
14			Eligible	
15			Expenses	
16	-Beyond the			
17	Additional 365 days	\$0	\$0	All Costs
18	SKILLED NURSING FACILITY			
19	CARE*			
20	You must meet Medicare's			
21	requirements, including			
22	having been in a hospital			
23	for at least 3 days and			
24	entered a Medicare-			
25	approved facility within			
26	30 days after leaving the			
27	hospital			
28	First 20 days	All approved		
29		amounts	\$0	\$0

1	21st thru 100th day	All but	Up to	\$0
2		\$124 \$161 a day	\$124 \$161	
3			a day	
4	101st day and after	\$0	\$0	All costs
5	BLOOD			
6	First 3 pints	\$0	3 pints	\$0
7	Additional amounts	100%	\$0	\$0
8	HOSPICE CARE			
9		All but very		\$0
10		limited	Medicare	
11		copayment/	copayment/	
12		coinsurance	coinsurance	
13	You must meet	for outpatient		
14	Medicare's requirements,	drugs and		
15	including a doctor's	inpatient		
16	certification of	respite care		
17	terminal illness			

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

25 **PLAN G OR HIGH-DEDUCTIBLE PLAN G**
 26 MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

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

**** THIS HIGH-DEDUCTIBLE PLAN PAYS THE SAME BENEFITS AS PLAN G AFTER ONE HAS PAID A CALENDAR YEAR \$2,180 DEDUCTIBLE. BENEFITS FROM THE HIGH-DEDUCTIBLE PLAN G WILL NOT BEGIN UNTIL OUT-OF-POCKET EXPENSES ARE \$2,180. 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 \$2,180 DEDUCTIBLE, **	IN ADDITION TO PAY \$2,180 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,			

1	physical and speech			
2	therapy, diagnostic			
3	tests, durable medical			
4	equipment,			
5	First \$131 of			
6	Medicare Approved	\$0	\$0	\$131 \$0
7	Amounts*			(UNLESS
8				Part B
9				Deductible
10				HAS NOT
11				BEEN MET)
12	Remainder of Medicare			
13	Approved Amounts	80%	20%	\$0
14	Part B Excess Charges			
15	(Above Medicare			
16	Approved Amounts)	\$0	100%	0%
17	BLOOD			
18	First 3 pints	\$0	All Costs	\$0
19	Next \$131 of			
20	Medicare Approved	\$0	\$0	\$131 \$0
21	Amounts*			(UNLESS
22				Part B
23				Deductible
24				HAS NOT
25				BEEN MET)
26	Remainder of Medicare			
27	Approved Amounts	80%	20%	\$0
28	CLINICAL LABORATORY			
29	SERVICES—			

1	Tests for			
2	diagnostic services	100%	\$0	\$0

3 PARTS A & B

4	HOME HEALTH CARE			
5	Medicare Approved			
6	Services			
7	-Medically necessary			
8	skilled care services			
9	and medical supplies	100%	\$0	\$0
10	-Durable medical			
11	equipment			
12	First \$131 \$166 of			
13	Medicare Approved	\$0	\$0	\$131 \$0
14	Amounts*			(UNLESS
15				Part B
16				Deductible
17				HAS NOT
18				BEEN MET)
19	Remainder of Medicare			
20	Approved Amounts	80%	20%	\$0

21 OTHER BENEFITS—NOT COVERED BY MEDICARE

22	FOREIGN TRAVEL—			
----	-----------------	--	--	--

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

15 PLAN K

16 *You will pay half the cost-sharing of some covered services
 17 until you reach the annual out-of-pocket limit of \$4,140 each
 18 calendar year. The amounts that count toward your annual limit
 19 are noted with diamonds¹ in the chart below. Once you reach the
 20 annual limit, the plan pays 100% of your Medicare copayment and
 21 coinsurance for the rest of the calendar year. However, this
 22 limit does NOT include charges from your provider that exceed
 23 Medicare-approved amounts (these are called "Excess Charges") and
 24 you will be responsible for paying this difference in the amount
 25 charged by your provider and the amount paid by Medicare for the
 26 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	\$496 (50% of Part A Deductible)	\$496 (50% of Part A Deductible)
61st thru 90th day	All but \$248 a day	\$248 a day	\$0
91st day and after:			
—While using 60 lifetime reserve days	All but \$496 a day	\$496 a day	\$0
—Once lifetime reserve			

1	days are used:			
2	-Additional 365 days	\$0	100% of	\$0***
3			Medicare	
4			Eligible	
5			Expenses	
6	-Beyond the			
7	Additional 365 days	\$0	\$0	All Costs
8	SKILLED NURSING FACILITY			
9	CARE**			
10	You must meet Medicare's			
11	requirements, including			
12	having been in a hospital			
13	for at least 3 days and			
14	entered a Medicare-			
15	approved facility within			
16	30 days after leaving the			
17	hospital			
18	First 20 days	All approved		
19		amounts	\$0	\$0
20	21st thru 100th day	All but	Up to	Up to
21		\$124 a	\$62	\$62
22		day	a day	a day 1
23	101st day and after	\$0	\$0	All costs
24	BLOOD			
25	First 3 pints	\$0	50%	50% 1
26	Additional amounts	100%	\$0	\$0
27	HOSPICE CARE			
28			50% of	50% of
29			copayment/	Medicare

1			coinsur-	copayment/
2			ance	coinsurance 1
3	You must meet			
4	Medicare's requirements,			
5	including a doctor's			
6	certification of terminal			
7	illness	All but very		
8		limited		
9		copayment/		
10		coinsurance for		
11		outpatient		
12		drugs and		
13		inpatient		
14		respite care		

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

22 PLAN K

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

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

1	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
2	MEDICAL EXPENSES—			
3	In or out of the hospital			
4	and outpatient hospital			
5	treatment, such as			
6	Physician's services,			
7	inpatient and outpatient			
8	medical and surgical			
9	services and supplies,			
10	physical and speech			
11	therapy, diagnostic			
12	tests, durable medical			
13	equipment,			
14	First \$131 of			
15	Medicare Approved	\$0	\$0	\$131
16	Amounts****			(Part B
17				Deductible)
18				**** 1
19				
20	Preventive Benefits for	Generally 75%	Remainder	All costs
21	Medicare covered	or more of	of Medi-	above Medi-
22	services	Medicare ap-	care	care
23		proved amounts	approved	approved
24			amounts	amounts
25	Remainder of Medicare	Generally 80%	Generally	Generally
26	Approved Amounts		10%	10% 1
27				
28	Part B Excess Charges	\$0	\$0	All costs

1	(Above Medicare			(and they do
2	Approved Amounts)			not count
3				toward
4				annual out-
5				of-pocket
6				limit of
7				\$4,140)*
8	BLOOD			
9	First 3 pints	\$0	50%	50% 1
10	Next \$131 of			
11	Medicare Approved	\$0	\$0	\$131
12	Amounts****			(Part B
13				Deductible)
14				**** 1
15	Remainder of Medicare	Generally 80%	Generally	Generally
16	Approved Amounts		10%	10% 1
17	CLINICAL LABORATORY			
18	SERVICES—Tests for			
19	diagnostic services	100%	\$0	\$0

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

27 PARTS A & B

1	HOME HEALTH CARE			
2	Medicare Approved			
3	Services			
4	Medically necessary			
5	skilled care services			
6	and medical supplies	100%	\$0	\$0
7	Durable medical			
8	equipment			
9	First \$131 of			
10	Medicare Approved	\$0	\$0	\$131
11	Amounts*****			(Part B
12				Deductible) 1
13	Remainder of Medicare			
14	Approved Amounts	80%	10%	10% 1

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

17 PLAN L

18 *You will pay one-fourth of the cost-sharing of some covered
 19 services until you reach the annual out-of-pocket limit of \$2,070
 20 each calendar year. The amounts that count toward your annual
 21 limit are noted with diamonds¹ in the chart below. Once you reach
 22 the annual limit, the plan pays 100% of your Medicare copayment
 23 and coinsurance for the rest of the calendar year. However, this
 24 limit does NOT include charges from your provider that exceed

1 Medicare-approved amounts (these are called "Excess Charges") and
 2 you will be responsible for paying this difference in the amount
 3 charged by your provider and the amount paid by Medicare for the
 4 item or service.

5 PLAN L

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

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

11	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
12	HOSPITALIZATION**			
13	Semiprivate room and			
14	board, general nursing			
15	and miscellaneous			
16	services and supplies			
17	First 60 days	All but	\$744	\$248
18		\$992	(75% of	(25% of
19			Part A	Part A
20			Deducti-	Deductible) 1
21			ble)	
22	61st thru 90th day	All but	\$248	\$0
23		\$248 a day	a day	
24	91st day and after:			
25	—While using 60			
26	lifetime reserve days	All but	\$496	\$0

1		\$496 a day	a day	
2	-Once lifetime reserve			
3	days are used:			
4	-Additional 365 days	\$0	100% of	\$0***
5			Medicare	
6			Eligible	
7			Expenses	
8	-Beyond the			
9	Additional 365 days	\$0	\$0	All Costs
10	SKILLED NURSING FACILITY			
11	CARE**			
12	You must meet Medicare's			
13	requirements, including			
14	having been in a hospital			
15	for at least 3 days and			
16	entered a Medicare-			
17	approved facility within			
18	30 days after leaving the			
19	hospital			
20	First 20 days	All approved		
21		amounts	\$0	\$0
22	21st thru 100th day	All but	Up to	Up to
23		\$124 a	\$93	\$31
24		day	a day	a day 1
25	101st day and after	\$0	\$0	All costs
26	BLOOD			
27	First 3 pints	\$0	75%	25% 1
28	Additional amounts	100%	\$0	\$0
29	HOSPICE CARE			

1			75% of	25% of
2			copayment/	copayment/
3			coinsur-	coinsurance 1
4			ance	
5	You must meet			
6	Medicare's requirements,			
7	including a doctor's			
8	certification of terminal	All		
9	illness	but very		
10		limited copay-		
11		ment/coinsur-		
12		ance for		
13		outpatient		
14		drugs and		
15		inpatient		
16		respite care		

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

24 PLAN L

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

26 ****Once you have been billed \$131 of Medicare-Approved

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

3	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
4	MEDICAL EXPENSES—			
5	In or out of the hospital			
6	and outpatient hospital			
7	treatment, such as			
8	Physician's services,			
9	inpatient and outpatient			
10	medical and surgical			
11	services and supplies,			
12	physical and speech			
13	therapy, diagnostic			
14	tests, durable medical			
15	equipment,			
16	First \$131 of			
17	Medicare Approved	\$0	\$0	\$131
18	Amounts****			(Part
19				B Deducti-
20				ble)**** 1
21	Preventive Benefits for	Generally 75%	Remainder	All costs
22	Medicare covered	or more of	of Medi-	above Medi-
23	services	Medicare	care	care
24		approved	approved	approved
25		amounts	amounts	amounts
26	Remainder of Medicare	Generally	Generally	Generally
27	Approved Amounts	80%	15%	5% 1
28				

1	Part B Excess Charges	\$0	\$0	All costs
2	(Above Medicare			(and they do
3	Approved Amounts)			not count
4				toward
5				annual out-
6				of-pocket
7				limit of
8				\$2,070) *
9	BLOOD			
10	First 3 pints	\$0	75%	25% 1
11	Next \$131 of			
12	Medicare Approved	\$0	\$0	\$131
13	Amounts****			(Part B
14				Deductible) 1
15	Remainder of Medicare	Generally	Generally	Generally
16	Approved Amounts	80%	15%	5% 1
17	CLINICAL LABORATORY			
18	SERVICES—Tests for			
19	diagnostic services	100%	\$0	\$0

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

27 PARTS A & B

1	HOME HEALTH CARE			
2	Medicare Approved			
3	Services			
4	Medically necessary			
5	skilled care services			
6	and medical supplies	100%	\$0	\$0
7	Durable medical			
8	equipment			
9	First \$131 of			
10	Medicare Approved	\$0	\$0	\$131
11	Amounts*****			(Part
12				B Deducti-
13				ble) 1
14	Remainder of Medicare			
15	Approved Amounts	80%	15%	5% 1

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

18 PLAN M

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

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

24	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
----	----------	---------------	-----------	---------

1	HOSPITALIZATION*			
2	Semiprivate room and			
3	board, general nursing			
4	and miscellaneous			
5	services and supplies			
6	First 60 days	All but \$992	\$496 (50%	\$496 (50%
7			of Part A	of Part A
8			Deduc-	Deduc-
9			tible)	tible)
10	61st thru 90th day	All but \$248	\$248	\$0
11		a day	a day	
12	91st day and after:			
13	-While using 60			
14	lifetime reserve days	All but \$496	\$496	\$0
15		a day	a day	
16	-Once lifetime reserve			
17	days are used:			
18	-Additional 365 days	\$0	100% of	\$0**
19			Medicare	
20			Eligible	
21			Expenses	
22	-Beyond the			
23	Additional 365 days	\$0	\$0	All Costs
24	SKILLED NURSING FACILITY			
25	CARE*			
26	You must meet Medicare's			
27	requirements, including			
28	having been in a hospital			
29	for at least 3 days and			

1	entered a Medicare-			
2	approved facility within			
3	30 days after leaving the			
4	hospital			
5	First 20 days	All approved	\$0	\$0
6		amounts		
7	21st thru 100th day	All but \$124	Up to \$124	\$0
8		a day	a day	
9	101st day and after	\$0	\$0	All costs
10	BLOOD			
11	First 3 pints	\$0	3 pints	\$0
12	Additional amounts	100%	\$0	\$0
13	HOSPICE CARE			
14	You must meet Medicare's	All but very	Medicare	\$0
15	requirements, including	limited	copayment/	
16	a doctor's	copayment/	coinsurance	
17	certification of	coinsurance		
18	terminal illness	for outpatient		
19		drugs and		
20		inpatient		
21		respite care		

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

PLAN M

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

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

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

1	Part B Excess Charges			
2	(Above Medicare			
3	Approved Amounts)	\$0	\$0	All costs
4	BLOOD			
5	First 3 pints	\$0	All costs	\$0
6	Next \$131 of Medicare			
7	Approved Amounts*	\$0	\$0	\$131
8				(Part B
9				Deduc-
10				tible)
11	Remainder of Medicare			
12	Approved Amounts	80%	20%	\$0
13	CLINICAL LABORATORY			
14	SERVICES—Tests for			
15	diagnostic services	100%	\$0	\$0

16 PARTS A & B

17	HOME HEALTH CARE			
18	Medicare Approved			
19	Services			
20	—Medically necessary			
21	skilled care services			
22	and medical supplies	100%	\$0	\$0
23	—Durable medical			
24	equipment			
25	First \$131 of			
26	Medicare Approved			

1	Amounts	\$0	\$0	\$131
2				(Part B
3				Deduc-
4				tible)
5	Remainder of Medicare			
6	Approved Amounts	80%	20%	\$0

7 OTHER BENEFITS—NOT COVERED BY MEDICARE

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

23 PLAN N

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

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

5	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
6	HOSPITALIZATION*			
7	Semiprivate room and			
8	board, general nursing			
9	and miscellaneous			
10	services and supplies			
11	First 60 days	All but \$992	\$992	\$0
12			(Part A	
13			Deduc-	
14			tible)	
15	61st thru 90th day	All but \$248	\$248	\$0
16		a day	a day	
17	91st day and after:			
18	-While using 60			
19	lifetime reserve days	All but \$496	\$496	\$0
20		a day	a day	
21	-Once lifetime reserve			
22	days are used:			
23	-Additional 365 days	\$0	100% of	\$0**
24			Medicare	
25			Eligible	
26			Expenses	
27	-Beyond the			

1	Additional 365 days	\$0	\$0	All Costs
2	SKILLED NURSING FACILITY			
3	CARE*			
4	You must meet Medicare's			
5	requirements, including			
6	having been in a hospital			
7	for at least 3 days and			
8	entered a Medicare-			
9	approved facility within			
10	30 days after leaving the			
11	hospital			
12	First 20 days	All approved	\$0	\$0
13		amounts		
14	21st thru 100th day	All but \$124	Up to \$124	\$0
15		a day	a day	
16	101st day and after	\$0	\$0	All costs
17	BLOOD			
18	First 3 pints	\$0	3 pints	\$0
19	Additional amounts	100%	\$0	\$0
20	HOSPICE CARE			
21	You must meet Medicare's	All but very	Medicare	\$0
22	requirements, including	limited	copayment/	
23	a doctor's certification	copayment/	coinsurance	
24	of terminal illness	coinsurance		
25		for outpatient		
26		drugs and		
27		inpatient		
28		respite care		

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

8 PLAN N
9 MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

10 *Once you have been billed \$131 of Medicare-approved amounts
11 for covered services (which are noted with an asterisk), your
12 Part B deductible will have been met for the calendar year.

13	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
14	MEDICAL EXPENSES—			
15	IN OR OUT OF THE			
16	HOSPITAL AND OUTPATIENT			
17	HOSPITAL TREATMENT, such			
18	as physician's services,			
19	inpatient and outpatient			
20	medical and surgical			
21	services and supplies,			
22	physical and speech			
23	therapy, diagnostic			
24	tests, durable medical			
25	equipment			
26	First \$131 of Medicare			

1	Approved Amounts*	\$0	\$0	\$131
2				(Part B
3				Deduc-
4				tible)
5	Remainder of Medicare			
6	Approved Amounts	Generally	Balance,	Up to \$20
7		80%	other than	per office
8			up to \$20	visit and
9			per office	up to \$50
10			visit and	per
11			up to \$50	emergency
12			per	room
13			emergency	visit. The
14			room visit.	copayment
15			The	of up to
16			copayment	\$50 is
17			of up to	waived if
18			\$50 is	the
19			waived if	insured is
20			the insured	admitted
21			is admitted	to any
22			to any	hospital
23			hospital	and the
24			and the	emergency
25			emergency	visit is
26			visit is	covered as
27			covered as	a Medicare
28			a Medicare	Part A
29			Part A	expense.

1			expense.	
2	Part B Excess Charges			
3	(Above Medicare			
4	Approved Amounts)	\$0	\$0	All costs
5	BLOOD			
6	First 3 pints	\$0	All costs	\$0
7	Next \$131 of Medicare			
8	Approved Amounts*	\$0	\$0	\$131
9				(Part B
10				Deduc-
11				tible)
12	Remainder of Medicare			
13	Approved Amounts	80%	20%	\$0
14	CLINICAL LABORATORY			
15	SERVICES—Tests for			
16	diagnostic services	100%	\$0	\$0

17 PARTS A & B

18	HOME HEALTH CARE			
19	Medicare Approved			
20	Services			
21	—Medically necessary			
22	skilled care services			
23	and medical supplies	100%	\$0	\$0
24	—Durable medical			
25	equipment			
26	First \$131 of			

1	Medicare Approved			
2	Amounts*	\$0	\$0	\$131
3				(Part B
4				Deduc-
5				tible)
6	Remainder of Medicare			
7	Approved Amounts	80%	20%	\$0

8 OTHER BENEFITS—NOT COVERED BY MEDICARE

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

24 Sec. 3819a. (1) This section applies to all ~~medicare~~
 25 **MEDICARE** supplement policies or certificates delivered or issued

1 for delivery with an effective date for coverage on or after June
2 1, 2010.

3 (2) An insurance policy ~~shall~~**MUST** not be titled,
4 advertised, solicited, or issued for delivery in this state as a
5 ~~medicare~~**MEDICARE** supplement policy if the policy does not meet
6 the minimum standards prescribed in this section. These minimum
7 standards are in addition to all other requirements of this
8 chapter. An issuer shall not offer any 1990 plan for sale on or
9 after June 1, 2010. Benefit standards applicable to ~~medicare~~
10 **MEDICARE** supplement policies and certificates issued before June
11 1, 2010 remain subject to the requirements of section 3819.

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

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

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

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

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

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

7 (e) Termination of a ~~medicare~~**MEDICARE** supplement policy
8 ~~shall~~**MUST** not reduce or limit the payment of benefits for any
9 continuous loss that commenced while the policy was in force, but
10 the extension of benefits beyond the period during which the
11 policy was in force may be predicated ~~upon~~**ON** the continuous
12 total disability of the insured, limited to the duration of the
13 policy benefit period, if any, or payment of the maximum
14 benefits. Receipt of ~~medicare~~**MEDICARE** part D benefits will not
15 be considered in determining a continuous loss.

16 (f) A ~~medicare~~**MEDICARE** supplement policy ~~shall~~**MUST** not
17 provide for termination of coverage of a spouse solely because of
18 the occurrence of an event specified for termination of coverage
19 of the insured, other than the nonpayment of premium.

20 (4) A ~~medicare~~**MEDICARE** supplement policy ~~shall~~**MUST** provide
21 that benefits and premiums under the policy ~~shall~~**WILL** be
22 suspended at the request of the policyholder or certificate
23 holder for a period not to exceed 24 months in which the
24 policyholder or certificate holder has applied for and is
25 determined to be entitled to medical assistance under ~~medicaid,~~
26 **MEDICAID**, but only if the policyholder or certificate holder
27 notifies the insurer of ~~such~~**THE** assistance within 90 days after

1 the date the individual becomes entitled to the assistance. ~~Upon~~
 2 **ON** receipt of timely notice, the insurer shall return to the
 3 policyholder or certificate holder that portion of the premium
 4 attributable to the period of ~~medicaid~~ **MEDICAID** eligibility,
 5 subject to adjustment for paid claims. If a suspension occurs and
 6 if the policyholder or certificate holder loses entitlement to
 7 medical assistance under ~~medicaid~~, **MEDICAID**, the policy ~~shall~~
 8 **MUST** be automatically reinstituted effective as of the date of
 9 termination of the assistance if the policyholder or certificate
 10 holder provides notice of loss of ~~medicaid~~ **MEDICAID** medical
 11 assistance within 90 days after the date of the loss and pays the
 12 premium attributable to the period effective as of the date of
 13 termination of the assistance. ~~Each medicare~~ **A MEDICARE**
 14 supplement policy ~~shall~~ **MUST** provide that benefits and premiums
 15 under the policy ~~shall~~ **WILL** be suspended at the request of the
 16 policyholder if the policyholder is entitled to benefits under
 17 ~~section 226(b) of title II of the social security act~~ **42 USC**
 18 **426(B)**, and is covered under a group health plan as defined in
 19 ~~section 1862(b) (1) (A) (v) of the social security act.~~ **42 USC**
 20 **1395Y (B) (1) (A) (v)**. If suspension occurs and if the policyholder
 21 or certificate holder loses coverage under the group health plan,
 22 the policy ~~shall~~ **MUST** be automatically reinstituted effective as
 23 of the date of loss of coverage if the policyholder provides
 24 notice of loss of coverage within 90 days after the date of the
 25 loss and pays the premium attributable to the period, effective
 26 as of the date of termination of enrollment in the group health
 27 plan. All of the following apply to the reinstitution of a

1 ~~medicare~~**MEDICARE** supplement policy under this subsection:

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

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

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

12 Sec. 3827. (1) A ~~medicare~~**MEDICARE** supplement insurance
13 policy or certificate ~~shall~~**MUST** not be delivered or issued for
14 delivery in this state if the policy or certificate provides
15 benefits that duplicate benefits provided by ~~medicare~~**MEDICARE**.

16 (2) Application forms or a supplementary application or
17 other form to be signed by the applicant and agent for ~~medicare~~
18 **MEDICARE** supplement policies, ~~shall~~**WHICH MAY BE PROVIDED IN**
19 **WRITTEN OR ELECTRONIC FORMAT, MUST** include the following
20 statements and questions designed to inform and elicit
21 information as to whether, ~~as of~~**ON** the date of the application,
22 the applicant ~~currently has~~ ~~medicare~~**MEDICARE** supplement,
23 ~~medicare~~**MEDICARE** advantage, ~~medicaid~~**MEDICAID** coverage, or
24 another health insurance policy or certificate in force or
25 whether a ~~medicare~~**MEDICARE** supplement policy or certificate is
26 intended to replace any ~~disability or other~~ health policy or
27 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

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

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

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

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

1 coverage is a wise decision.

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

4 (Use additional sheets as necessary.)

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

13 ☐ Additional benefits

14 ☐ No change in benefits, but lower premiums

15 ☐ Fewer benefits and lower premiums

16 ☐ My plan has outpatient prescription drug coverage and
17 I am enrolling in part D

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

21 ☐ Other. (Please specify)

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

1 application of a new pre-existing condition limitation.

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

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

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

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

25 _____
26 Typed Name and Address of Agent or Broker

1

2 (Date)

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

4

5 (Date)

6

7 (Applicant's Signature)

8

9 (Applicant's Printed Name)

10

11 (Applicant's Address)

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

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

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

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

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

22 (a) One or more of the following:

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

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

27 (iii) Liability insurance, including general liability

1 insurance and automobile liability insurance.

2 (iv) Workers' compensation or similar insurance.

3 (v) Automobile medical payment insurance.

4 (vi) Credit-only insurance.

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

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

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

12 (i) Limited scope dental or vision benefits.

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

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

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

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

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

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

25 (i) Medicare supplemental policy as defined ~~under section~~
26 ~~1882(g)(1) of part D of medicare, IN 42 U.S.C. USC 1395ss.~~

27 (ii) Coverage supplemental to the coverage provided under

1 chapter 55 of title 10 of the United States Code, 10 ~~U.S.C.~~ **USC**
 2 1071 to ~~1109.~~ **1110B.**

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

5 Sec. 3831. (1) Each insurer offering ~~individual or group~~
 6 expense incurred hospital, medical, or surgical policies or
 7 certificates in this state shall provide without restriction, to
 8 any person who requests coverage from an insurer and has been
 9 insured with an ~~THE~~ insurer, ~~subject to this section,~~ if the
 10 person ~~would no longer be insured because he or she has become~~
 11 ~~eligible for medicare or if the person loses coverage under a~~
 12 group policy after becoming eligible for ~~medicare,~~ **MEDICARE**, a
 13 right of continuation or conversion to their choice of the basic
 14 core benefits as described in section 3807 or 3807a ~~or a type C~~
 15 ~~medicare supplemental package as described in section 3811(5)(c)~~
 16 ~~or 3811a(6)(c)~~ that is guaranteed renewable or noncancellable. A
 17 person who is hospitalized or has been informed by a physician
 18 that he or she will require hospitalization within 30 days after
 19 the time of application ~~shall~~ **IS** not be entitled to coverage
 20 under this subsection until the day following the date of
 21 discharge. However, if the hospitalized person was insured by the
 22 insurer immediately ~~prior to~~ **BEFORE** becoming eligible for
 23 ~~medicare~~ **MEDICARE** or immediately ~~prior to~~ **BEFORE** losing coverage
 24 under a group policy after becoming eligible for ~~medicare,~~
 25 **MEDICARE**, the person ~~shall be~~ **IS** eligible for immediate coverage
 26 from the previous insurer under this subsection. A person ~~shall~~
 27 **IS** not be entitled to a ~~medicare~~ **MEDICARE** supplemental policy

1 under this subsection unless the person presents satisfactory
2 proof to the insurer that he or she was insured with an insurer
3 subject to this section. A person who wishes coverage under this
4 subsection must either request coverage within 90 days before or
5 90 days after the month he or she becomes eligible for ~~medicare~~
6 **MEDICARE** or request coverage within 180 days after losing
7 coverage under a group policy. A person 60 years of age or older
8 who loses coverage under a group policy is entitled to coverage
9 under a ~~medicare~~**MEDICARE** supplemental policy without restriction
10 from the insurer providing the former group coverage, if he or
11 she requests coverage within 90 days before or 90 days after the
12 month he or she becomes eligible for ~~medicare~~**MEDICARE**.

13 (2) Except as provided in section 3833, a person not insured
14 under an individual or group hospital, medical, or surgical
15 expense incurred policy as specified in subsection (1), after
16 applying for coverage under a ~~medicare~~**MEDICARE** supplemental
17 policy required to be offered under subsection (1), ~~shall be~~**IS**
18 entitled to coverage under a ~~medicare~~**MEDICARE** supplemental
19 policy that may include a provision for exclusion from
20 preexisting conditions for 6 months after the inception of
21 coverage, consistent with the provisions of section 3819(2)(a) or
22 3819a(3)(a).

23 (3) Each insurer offering individual expense incurred
24 hospital, medical, or surgical policies in this state shall give
25 to each person who is insured with the insurer at the time he or
26 she becomes eligible for ~~medicare~~**MEDICARE**, and to each
27 applicant of the insurer who is eligible for ~~medicare~~**MEDICARE**, written

1 notice of the availability of coverage under this section. Each
2 group policyholder providing hospital, medical, or surgical
3 expense incurred coverage in this state shall give to each
4 certificate holder who is covered at the time he or she becomes
5 eligible for ~~medicare~~, **MEDICARE**, written notice of the
6 availability of coverage under this section.

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

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

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

20 (c) The insurer remains responsible for providing ~~medicare~~
21 **MEDICARE** supplemental coverage to its policyholders ~~in the event~~
22 ~~that~~ **IF** the other insurer no longer provides coverage and another
23 insurer is not found to take its place.

24 (d) The insurer provides certification from an executive
25 officer for the specific insurer or affiliate of the insurer
26 wishing to utilize this option. This certification ~~shall~~ **MUST**
27 identify the process provided in subdivisions (a) ~~through~~ **TO** (c)

1 and ~~shall~~**MUST** clearly state that the insurer understands that
2 the ~~commissioner~~**DIRECTOR** may void this arrangement if the
3 affiliate fails to ensure that eligible policyholders are
4 immediately offered ~~medicare~~**MEDICARE** supplemental policies.

5 (e) The insurer certifies to the ~~commissioner~~**DIRECTOR** that
6 it is in the process of discontinuing in ~~Michigan~~**THIS STATE** its
7 offering of individual or group expense incurred hospital,
8 medical, or surgical policies or certificates.

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

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

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

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

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

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

26 (3) Any sale of ~~medicare~~**MEDICARE** supplement coverage that
27 will provide an individual with more than 1 ~~medicare~~**MEDICARE**

1 supplement policy, certificate, or contract is prohibited.

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

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

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

20 (2) If a ~~medicare~~**MEDICARE** supplement policy is terminated
21 by the group policyholder and is not replaced as provided under
22 subsection (4), the issuer shall offer certificate holders an
23 individual ~~medicare~~**MEDICARE** supplement policy that at the option
24 of the certificate holder provides for continuation of the
25 benefits contained in the group policy or provides for such
26 benefits as otherwise meet the requirements of section 3819 or
27 3819a.

1 (3) If an individual is a certificate holder in a group
2 ~~medicare~~**MEDICARE** supplement policy and the individual terminates
3 membership in the group, the issuer shall offer the certificate
4 holder the conversion opportunity described in subsection (2) or
5 (4) or at the option of the group policyholder, offer the
6 certificate holder continuation of coverage under the group
7 policy.

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

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

21 (6) ON OR AFTER JANUARY 1, 2020, IF AN INDIVIDUAL IS A
22 CERTIFICATE OR POLICYHOLDER IN A MEDICARE SUPPLEMENT PLAN C, PLAN
23 F, OR PLAN F HIGH DEDUCTIBLE, AS DESCRIBED IN SECTION 3811 OR
24 3811A, AS APPLICABLE, AND FAILS TO RENEW OR CONTINUE TO KEEP THE
25 MEDICARE SUPPLEMENT PLAN IN FORCE, THE INDIVIDUAL IS NOT ELIGIBLE
26 TO RETURN TO A MEDICARE SUPPLEMENT PLAN C, PLAN F, OR PLAN F
27 HIGH-DEDUCTIBLE PLAN, AS DESCRIBED IN SECTION 3811 OR 3811A, AS

1 **APPLICABLE.**

2 Sec. 3843. (1) ~~Any~~**A** policy or certificate of disability
 3 **HEALTH** insurance issued for delivery in this state to persons
 4 eligible for ~~medicare~~**MEDICARE** by reason of age ~~shall~~**MUST** notify
 5 insureds under the policy or certificate that the policy is not a
 6 ~~medicare~~**MEDICARE** supplement policy. The notice ~~shall~~**MUST** either
 7 be printed or attached to the first page of the coverage outline
 8 delivered to insureds under the policy or certificate, ~~or,~~ if a
 9 coverage outline is not delivered, to the first page of the
 10 policy or certificate delivered to insureds. The notice ~~shall~~
 11 **MUST** be in not less than 12-point type, and ~~shall~~**MUST** contain
 12 the following language:

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

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

- 23 (a) A ~~medicare~~**MEDICARE** supplement policy or certificate.
- 24 (b) A disability income policy or certificate.
- 25 (c) A single premium nonrenewable policy or certificate.

26 Sec. 3847. ~~Each~~**AN** insurer ~~providing medicare~~**THAT PROVIDES**
 27 **MEDICARE** supplement insurance coverage in this state shall file

1 with the ~~commissioner~~**DIRECTOR** for review a copy of any written,
2 radio, or television advertisement for ~~medicare~~**MEDICARE**
3 supplement insurance intended for use in this state at least 45
4 30 days before the date the insurer desires to use the
5 advertising. The filing ~~shall~~**MUST** include a sample or photocopy
6 of all applicable ~~medicare~~**MEDICARE** supplement policies and
7 related forms and the approval status of the policies and forms.

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

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