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:

HOUSE BILL No. 6431

Sec. 3801. As used in this chapter:

(a) "Applicant" means:

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

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

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

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

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

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

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

(*i*) A group health plan.

(*ii*) Health insurance coverage.

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

(*iv*) Medicaid other than coverage consisting solely of

benefits under ~~section 1928 of medicaid,~~ 42 USC 1396s.

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

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

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

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

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

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

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

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

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

(j) "Insurer" includes any ~~entity, including a health care corporation operating pursuant to the nonprofit health care~~

~~corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704,~~ ~~delivering~~ **PERSON THAT DELIVERS** or ~~issuing~~ **ISSUES** for delivery in this state ~~medicare~~ **MEDICARE** supplement policies.

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

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

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

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

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

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

(n) "Medicare supplement buyer's guide" means the document entitled, ~~"guide to health insurance for people with medicare",~~ **"CHOOSING A MEDIGAP POLICY: A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE"**, developed by the ~~national association of insurance commissioners~~ **NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS** and the United States ~~department of health and human services~~ **DEPARTMENT OF HEALTH AND HUMAN SERVICES**, or a

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

(o) "Medicare supplement policy" means an individual ~~,~~ ~~nongroup,~~ or group policy or certificate that is advertised, marketed, or designed primarily as a supplement to reimbursements under ~~medicare~~ **MEDICARE** for the hospital, medical, or surgical expenses of persons eligible for ~~medicare~~ **MEDICARE** and ~~medicare~~ **MEDICARE** select policies and certificates under section 3817. Medicare supplement policy does not include a policy, certificate, or contract of 1 or more employers or labor organizations, or of the trustees of a fund established by 1 or more employers or labor organizations, or both, for employees or former employees, or both, or for members or former members, or both, of the labor organizations. Medicare supplement policy does not include ~~medicare~~ **MEDICARE** advantage plans established under ~~medicare~~ **MEDICARE** part C, outpatient prescription drug plans established under ~~medicare~~ **MEDICARE** part D, or any health care prepayment plan that provides benefits pursuant to an agreement under ~~section 1833(a)(1)(A) of the social security act.~~**42 USC 1395*l*(A)(1).**

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

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

(r) "1990 standardized ~~medicare~~ **MEDICARE** supplement benefit

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

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

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

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

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

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

(2) Sections 3807, 3809, 3811, and 3819 apply to a ~~medicare~~ **MEDICARE** supplement policy delivered or issued for delivery in this state on or after June 2, 1992 with an effective date for coverage ~~prior to~~ **BEFORE** June 1, 2010.

(3) Sections 3807a, 3809a, 3811a, and 3819a apply to a

~~medicare~~ **MEDICARE** supplement policy delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010.

Sec. 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

home.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) In addition to the basic core package of benefits required under section 3807a, the following benefits may be included in a ~~medicare~~ **MEDICARE** supplement insurance policy and if included ~~shall~~ **MUST** conform to section ~~3811a(6)(b) to (j):~~**3811A(7)(B) TO (J):**

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) ~~(5)~~ In addition to the benefit plan designations as provided under subsection ~~(6),~~ **(7),** an insurer may use other 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**

FOR MEDICARE BEFORE JANUARY 1, 2020.

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

for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10.00. **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.**

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

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

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

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

(*iii*) ~~Upon~~ **ON** exhaustion of the ~~medicare~~ **MEDICARE** hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the ~~medicare~~ **MEDICARE** part A eligible expenses for

hospitalization paid at the applicable prospective payment system rate, or other appropriate ~~medicare~~ **MEDICARE** standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the insurer's payment as payment in full and may not bill the insured for any balance.

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

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

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

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

(*viii*) Except for coverage provided in subparagraph (*ix*), ~~below,~~ coverage for 50% of the cost sharing otherwise applicable

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DEDUCTIBLE.

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

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

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

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

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

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

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

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

(a) A cover page.

(b) Premium information.

(c) Disclosure pages.

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

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

(3) If an outline of coverage is provided at the time of application and the ~~medicare~~ **MEDICARE** supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate ~~shall~~ **MUST** accompany the policy or certificate when it is delivered and ~~shall~~ **MUST** contain the following statement, in ~~no~~ **NOT** less than 12-point type, immediately above the company name:

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

(4) An outline of coverage under subsection (1) ~~shall~~ **MUST** be in the language and **IN A WRITTEN OR ELECTRONIC** format prescribed in this section and in not less than 12-point type. The letter designation of the plan ~~shall~~ **MUST** be shown on the cover page and the plans offered by the insurer ~~shall~~ **MUST** be prominently identified. Premium information ~~shall~~ **MUST** be shown on the cover page or immediately following the cover page and ~~shall~~ **MUST** be prominently displayed. The premium and method of

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

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

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

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

BASIC BENEFITS:

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

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

Blood: First three pints of blood each year.

Hospice: Part A coinsurance

A	B	C**	D	F|F* **	G/**G***
Basic,	Basic,	Basic,	Basic,	Basic,	Basic,

including 100% Part B coinsurance	including 100% Part B coinsurance	including 100% Part B coinsurance	including 100% Part B coinsurance	including 100% Part B coinsurance	including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible	
				Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office

			visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $4,140; paid at 100% after limit reached	Out-of-pocket limit $2,070; paid at 100% after limit reached		

* ~~Plan~~ **PLANS** F **AND G** also ~~has an option~~ **HAVE OPTIONS** called ~~a~~ high-deductible Plan F ~~. This~~ **AND HIGH-DEDUCTIBLE PLAN G. THESE** high-deductible ~~plan pays~~ **PLANS PAY** the same benefits as Plan F **OR PLAN G, AS APPLICABLE,** after one has paid a calendar year ~~$1,860~~ **$2,180** deductible. Benefits from high-deductible Plan F **OR HIGH-DEDUCTIBLE PLAN G** will not begin until out-of-pocket expenses exceed ~~$1,860.~~ **$2,180.** Out-of-pocket expenses for ~~this deductible~~ **THESE DEDUCTIBLES** are expenses that would ordinarily be paid by the policy. These expenses include the Medicare

deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

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

PREMIUM INFORMATION

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

DISCLOSURES

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

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates ~~prior to~~ **BEFORE** June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. (This sentence ~~shall~~ **MUST** not appear after June 1, 2011.)

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

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

[For agent issued policies]

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

[For direct response issued policies]

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

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

for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

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

*A benefit period begins on the first day you receive

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $992	$0	$992 (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 days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY			

CARE*				
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital				
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $124 a day	$0	Up to $124 a day
101st day and after	$0	$0	All costs
BLOOD				
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE				
You must meet Medicare's requirements including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

PLAN A

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

*Once you have been billed $131 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	$0	$0	$131

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

PARTS A & B

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

—Durable medical equipment First $131 of Medicare Approved Amounts*	$0	$0	$131 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $992	$992 (Part A Deductible)	$0
61st thru 90th day	All but $248 a day	$248 a day	$0

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

Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

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

SERVICES—			
Tests for			
diagnostic services	100%	$0	$0

PARTS A & B

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

PLAN C

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

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

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

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

requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $124 a day	Up to $124 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

PLAN C

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	$131 (Part B Deductible)	$0

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

PARTS A & B

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

First $131 of Medicare Approved Amounts*	$0	$131 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN D

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

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

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

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital				
	First 20 days	All approved amounts	$0	$0
	21st thru 100th day	All but $124 a day	Up to $124 a day	$0
	101st day and after	$0	$0	All costs
BLOOD				
First 3 pints		$0	3 pints	$0
Additional amounts		100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness		All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN D

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

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

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

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

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services			

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN F OR ~~HIGH DEDUCTIBLE~~ **HIGH-DEDUCTIBLE** PLAN F

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

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

This ~~high deductible~~ **HIGH-DEDUCTIBLE plan pays the same benefits as plan F after you have paid a calendar year ~~($1,860)~~ **$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

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

	$124 a day	$124 a day	
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0
You must meet Medicare's requirements, including a doctor's certification of terminal illness			

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

PLAN F

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

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

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

This ~~high deductible~~ **HIGH-DEDUCTIBLE plan pays the same benefits as plan F after you have paid a calendar year ~~($1,860)~~ **$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
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	$0	$131	$0

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

PARTS A & B

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

—Durable medical equipment First $131 of Medicare Approved Amounts*	$0	$131 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN G **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			

First 60 days	All but ~~$992~~**$1,288**	~~$992~~**$1,288** (Part A Deductible)	$0
61st thru 90th day	All but ~~$248~~**$322** a day	~~$248~~**$322** a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but ~~$496~~**$644** a day	~~$496~~**$644** a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0

21st thru 100th day	All but ~~$124~~**$161** a day	Up to ~~$124~~**$161** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN G **OR HIGH-DEDUCTIBLE PLAN G**

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

*Once you have been billed $131 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,				

physical and speech therapy, diagnostic tests, durable medical equipment,			
First $131 of Medicare Approved Amounts*	$0	$0	~~$131~~**$0** (**UNLESS** Part B Deductible **HAS NOT BEEN MET**)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	0%
BLOOD			
First 3 pints	$0	All Costs	$0
Next $131 of Medicare Approved Amounts*	$0	$0	~~$131~~**$0** (**UNLESS** Part B Deductible **HAS NOT BEEN MET**)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			

Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First ~~$131~~ **$166** of Medicare Approved Amounts*	$0	$0	~~$131~~**$0** (**UNLESS** Part B Deductible **HAS NOT BEEN MET**)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL—			

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

PLAN K

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

PLAN K

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $992	$496 (50% of Part A Deductible)	$496 (50% of Part A Deductible)1
61st thru 90th day	All but $248 a day	$248 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $496 a day	$496 a day	$0
—Once lifetime reserve			

days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $124 a day	Up to $62 a day	Up to $62 a day 1
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50% 1
Additional amounts	100%	$0	$0
HOSPICE CARE		50% of copayment/	50% of Medicare

		coinsur-	copayment/
		ance	coinsurance 1
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care		

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

PLAN K

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $131 of Medicare Approved Amounts****	$0	$0	$131 (Part B Deductible) **** 1
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% 1
Part B Excess Charges	$0	$0	All costs

(Above Medicare Approved Amounts)			(and they do not count toward annual out-of-pocket limit of $4,140)*
BLOOD			
First 3 pints	$0	50%	50% 1
Next $131 of Medicare Approved Amounts****	$0	$0	$131 (Part B Deductible) **** 1
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% 1
CLINICAL LABORATORY SERVICES—Tests for diagnostic services	100%	$0	$0

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

PARTS A & B

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

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

PLAN L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,070 each calendar year. The amounts that count toward your annual limit are noted with diamonds[1] in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed

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

PLAN L

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $992	$744 (75% of Part A Deducti-ble)	$248 (25% of Part A Deductible) 1
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	$0

	$496 a day	a day	
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $124 a day	Up to $93 a day	Up to $31 a day 1
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25% 1
Additional amounts	100%	$0	$0
HOSPICE CARE			

		75% of copayment/ coinsur- ance	25% of copayment/ coinsurance 1
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copay- ment/coinsur- ance for outpatient drugs and inpatient respite care		

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

PLAN L

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

****Once you have been billed $131 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 Deducti-ble)**** 1
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medi-care approved amounts	All costs above Medi-care approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% 1

Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $2,070)*
BLOOD			
First 3 pints	$0	75%	25% 1
Next $131 of Medicare Approved Amounts****	$0	$0	$131 (Part B Deductible) 1
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% 1
CLINICAL LABORATORY SERVICES—Tests for diagnostic services	100%	$0	$0

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

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

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

PLAN M

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $992	$496 (50% of Part A Deduc-tible)	$496 (50% of Part A Deduc-tible)
61st thru 90th day	All but $248 a day	$248 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $496 a day	$496 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and			

entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $124 a day	Up to $124 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN M

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

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

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

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

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $131 of Medicare Approved			

Amounts	$0	$0	$131 (Part B Deduc-tible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN N

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

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

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

Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $124 a day	Up to $124 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $131 of Medicare			

Approved Amounts*	$0	$0	$131 (Part B Deduc-tible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.

		expense.	
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $131 of Medicare Approved Amounts*	$0	$0	$131 (Part B Deduc-tible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $131 of			

Medicare Approved Amounts*	$0	$0	$131 (Part B Deduc-tible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[STATEMENTS]

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

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

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

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

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

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

[QUESTIONS]

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

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

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

To the best of your knowledge,

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

Yes ____ No ____

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

Yes ____ No ____

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

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

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

Yes ____ No ____

If yes,

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

Yes ____ No ____

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

Yes ____ No ____

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

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

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

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

Yes ____ No ____

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

Yes ____ No ____

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

Yes ____ No ____

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

Yes ____ No ____

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

_____

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

Yes ____ No ____

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

Yes ____ No ____

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

_____

_____

_____

_____

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

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

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

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

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

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

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

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

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

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

coverage is a wise decision.

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

(Use additional sheets as necessary.)

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

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

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

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

_____ Other. (Please specify)

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

application of a new pre-existing condition limitation.

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

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

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

_____

Signature of Agent, Broker, or Other Representative

(* Signature not required for direct response sales.)

_____

Typed Name and Address of Agent or Broker

_____

(Date)

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

_____

(Date)

_____

(Applicant's Signature)

_____

(Applicant's Printed Name)

_____

(Applicant's Address)

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

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

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

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

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

(a) One or more of the following:

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

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

(*iii*) Liability insurance, including general liability

insurance and automobile liability insurance.

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

(*v*) Automobile medical payment insurance.

(*vi*) Credit-only insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

supplement policy, certificate, or contract is prohibited.

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

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

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

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

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

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

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

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

APPLICABLE.

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

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

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

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

(b) A disability income policy or certificate.

(c) A single premium nonrenewable policy or certificate.

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

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

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

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