Act No. 429
Public Acts of 2018
Approved by the Governor
December 19, 2018
Filed with the Secretary of State
December 20, 2018
EFFECTIVE DATE: March 20, 2019

STATE OF MICHIGAN
99TH LEGISLATURE
REGULAR SESSION OF 2018

Introduced by Rep. Vaupel

ENROLLED HOUSE BILL No. 6431

AN ACT to amend 1956 PA 218, entitled "An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to provide for the imposition of regulatory fees on certain insurers; to provide for assessment fees on certain health maintenance organizations; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for regulation over worker's compensation self-insurers; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to provide for an appropriation; to repeal acts and parts of acts; and to provide penalties for the violation of this act," by amending sections 2266, 3801, 3803, 3811a, 3813, 3815, 3819a, 3827, 3829, 3831, 3835, 3843, and 3847 (MCL 500.2266, 500.3801, 500.3803, 500.3811a, 500.3813, 500.3815, 500.3819a, 500.3827, 500.3829, 500.3831, 500.3835, 500.3843, and 500.3847), section 2266 as added by 2018 PA 205, sections 3801, 3803, 3815, and 3831 as amended and sections 3811a and 3819a as added by 2009 PA 220, sections 3813, 3843, and 3847 as added by 1992 PA 84, sections 3827 and 3835 as amended by 2006 PA 462, and section 3829 as amended by 2002 PA 304, and by adding section 3811b; and to repeal acts and parts of acts.

The People of the State of Michigan enact:

Sec. 2266. (1) Subject to the requirements of this section, a notice to a party or any other document that is required in an insurance transaction or that is to serve as evidence of insurance coverage may be delivered, stored, and presented

by electronic means if it meets the requirements of the uniform electronic transactions act, 2000 PA 305, MCL 450.831 to 450.849.

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

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

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

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

(b) Before obtaining consent, the insurer provides the party with a clear and conspicuous statement informing the party of all of the following:

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

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

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

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

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

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

(5) After the party consents as provided in subsection (4), if a change occurs in hardware or software needed to access or retain a notice or document delivered by electronic means that creates a material risk that the party will not be able to access or retain a notice or document to which consent applies, the insurer shall provide the party with a statement that includes all of the following:

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

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

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

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

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

(9) This section must not be construed to modify, limit, or supersede the federal electronic signatures in global national commerce act, 15 USC 7001 to 7031.

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

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

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

(11) This section does not apply to a health insurer or health maintenance organization.

(12) As used in this section:

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

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

(*ii*) Both of the following:

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

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

(b) "Party" means a recipient of a notice or document required as part of an insurance transaction and includes an applicant, insured, policy holder, or annuity contract holder.

Sec. 3801. As used in this chapter:

(a) "Applicant" means:

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

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

(b) "Bankruptcy" means, with respect to a 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 supplement policy.

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

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

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

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

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

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

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

(*x*) Health care under 22 USC 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 29 USC 1002.

(i) "Insolvency" means, 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 person that delivers or issues for delivery in this state Medicare supplement policies.

(k) "Medicaid" means subchapter XIX of the social security act, 42 USC 1396 to 1396w-5.

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

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

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

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

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

(n) "Medicare supplement buyer's guide" means the document entitled, "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare", developed by the National Association of Insurance Commissioners and the United States Department of Health and Human Services, or a substantially similar document as approved by the director.

(o) "Medicare supplement policy" means an individual or group policy or certificate that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses

of persons eligible for Medicare and Medicare select policies and certificates under section 3817. Medicare supplement policy does not include a policy, certificate, or contract of 1 or more employers or labor organizations, or of the trustees of a fund established by 1 or more employers or labor organizations, or both, for employees or former employees, or both, or for members or former members, or both, of the labor organizations. Medicare supplement policy does not include Medicare advantage plans established under Medicare part C, outpatient prescription drug plans established under Medicare part D, or any health care prepayment plan that provides benefits pursuant to an agreement under 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 supplement benefit plan", "prestandardized benefit plan", or "prestandardized plan" means a group or individual policy of Medicare supplement insurance issued before June 2, 1992.

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

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

(t) "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.

(v) "Social security act" means the social security act, 42 USC 301 to 1397mm.

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

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

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

Sec. 3811a. (1) This section applies to all Medicare 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 must not be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. Benefit plan standards applicable to 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 supplement policyholder and certificate holder a policy form or certificate form containing only the basic core benefits as provided in section 3807a. If an insurer makes available any of the additional benefits described in section 3809a or offers standardized benefit plans K or L, the insurer shall make available to each prospective Medicare supplement policyholder and certificate holder a policy form or certificate form containing either standardized benefit plan C or standardized benefit plan F.

(3) Groups, packages, or combinations of Medicare supplement benefits other than those listed in this section must not be offered for sale in this state except as may be permitted in subsection (6)(k).

(4) Benefit plans must be uniform in structure, language, designation, and format to the standard benefit plans in subsection (6) and must conform to the definitions in this chapter. Each benefit must be structured in accordance with sections 3807a and 3809a and list the benefits in the order shown in subsection (6). As used in this section, "structure, language, designation, and format" means style, arrangement, and overall content of a benefit.

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

(6) A Medicare supplement insurance benefit plan must conform to 1 of the following:

(a) A standardized Medicare supplement benefit plan A must be limited to the basic core benefits common to all benefit plans as required under section 3807a.

(b) A standardized Medicare supplement benefit plan B must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible as defined in section 3809a(2)(a).

(c) A standardized Medicare supplement benefit plan C must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, 100% of the Medicare part B deductible, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (d), and (f).

(d) A standardized Medicare supplement benefit plan D must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), and (f).

(e) A standardized Medicare supplement benefit plan F must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, 100% of the Medicare part B deductible, 100% of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (d), (e), and (f). A standardized Medicare supplement plan F high deductible must include only the following: 100% of covered expenses following the payment of the annual high-deductible plan F deductible. The covered expenses include the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, 100% of the Medicare part B deductible, 100% of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (d), (e), and (f). The annual high-deductible plan F deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan F policy, and must be in addition to any other specific benefit deductibles. The annual high-deductible plan F deductible is $1,500.00 for calendar year 1999, and the secretary shall adjust it annually thereafter to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10.00.

(f) A standardized Medicare supplement benefit plan G must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, 100% of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (e), and (f). Effective January 1, 2020, the standardized plan F high deductible benefit plan, redesignated in section 3811b(2)(d) as plan G high deductible, may be offered to an individual who was eligible for Medicare before January 1, 2020.

(g) Standardized Medicare supplement benefit plan K 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 benefit period.

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

(*iii*) On exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the insurer's payment as payment in full and may not bill the insured for any balance.

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

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

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

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

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

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

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

(h) Standardized Medicare supplement benefit plan L 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 supplement benefit plan M must include only the following: the core benefits as required under section 3807a and 50% of the Medicare part A deductible, skilled nursing care, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(b), (c), and (f).

(j) A standardized Medicare supplement benefit plan N must include only the following: the core benefits as required under section 3807a and 100% of the 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 part B coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists.

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

(k) New or innovative benefits: an insurer may, with the prior approval of the 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 supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. The innovative benefit must not include an outpatient prescription drug benefit. New or innovative benefits must not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

Sec. 3811b. (1) This section applies to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare after December 31, 2019. A policy or certificate that provides coverage of the Medicare part B deductible must not be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare after December 31, 2019, unless it complies with the benefit standards provided in this section. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020 remain subject to the requirements of section 3811a.

(2) The standards and requirements of section 3811a apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare after December 31, 2019, with the following exceptions:

(a) Standardized Medicare supplement benefit plan C is redesignated as plan D and must provide the benefits contained in section 3811a(6)(c), but must not provide coverage for 100% or any portion of the Medicare part B deductible.

(b) Standardized Medicare supplement benefit plan F is redesignated as plan G and must provide the benefits contained in section 3811a(6)(e), as applicable, but must not provide coverage for 100% or any portion of the Medicare part B deductible.

(c) Standardized Medicare supplement benefit plans C, F, and F high deductible may not be offered to individuals newly eligible for Medicare after December 31, 2019.

(d) Standardized Medicare supplement benefit plan F high deductible is redesignated as plan G high deductible and must provide the benefits in section 3811a(6)(e), as applicable, but must not provide coverage for 100% or any portion of the Medicare part B deductible. The Medicare part B deductible paid by the beneficiary is considered an out-of-pocket expense in meeting the annual high deductible.

(e) The reference to plan C or plan F contained in section 3811a(2) is deemed a reference to plan D or plan G, respectively, for purposes of this section.

(3) This section only applies to individuals that are newly eligible for Medicare after December 31, 2019 because of either of the following:

(a) By reason of attaining age 65 after December 31, 2019.

(b) By reason of entitlement to benefits under Medicare part A under section 226(b) or 226a of the social security act, or who is deemed to be eligible for benefits under section 226a of the social security act after December 31, 2019.

(4) For purposes of section 3830(5) to (8), for an individual newly eligible for Medicare after December 31, 2019, any reference to Medicare supplement policy or certificate plans C, F, or F high deductible is deemed to be a reference to Medicare supplement policy or certificate plans D, G, or G high deductible, respectively, that meet the requirements of subsection (2).

(5) After December 31, 2019, the standardized benefit plans described in subsection (2)(d) may be offered to an individual who was eligible for Medicare before January 1, 2020, in addition to the standardized plans described in section 3811a(6).

Sec. 3813. An insurer that issues a policy that provides health insurance coverage to a person eligible for Medicare by reason of age shall provide the prospective policyholder with a Medicare supplement buyer's guide in written or electronic format, which 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. However, for direct response solicitation policies, the guide must be furnished with the policy in written or electronic format and the insurer need not obtain acknowledgment of receipt. 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 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 under this section 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 prescription drug, improvement, and modernization act of 2003, Public Law 108-173.

(3) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and must contain the following statement, in 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 on application and the coverage originally applied for has not been issued.

(4) An outline of coverage under subsection (1) 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 must be shown on the cover page and the plans offered by the insurer must be prominently identified. Premium information must be shown on the cover page or immediately following the cover page and must be prominently displayed. The premium and method of payment mode must be stated for all plans that are offered to the applicant. All possible premiums for the applicant must be illustrated. The following items must be included in the outline of coverage in the order prescribed below and in substantially the following form, as approved by the 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 must not appear after June 1, 2011.)

BASIC BENEFITS:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
Blood: First three pints of blood each year.
Hospice: Part A coinsurance

A	B	C**	D	F|F* **	G/G*
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible	
				Part B Excess (100%)	Part B Excess (100%)
		Foreign 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 $5,240; paid at 100% after limit reached	Out-of-pocket limit $2,620; paid at 100% after limit reached		

* Plans F and G also have options called high-deductible Plan F and high-deductible Plan G. These high-deductible plans pay the same benefits as Plan F or Plan G, as applicable, after one has paid a calendar year $2,240 deductible. Benefits from high-deductible Plan F or high-deductible Plan G will not begin until out-of-pocket expenses exceed $2,240. Out-of-pocket expenses for 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 before June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. (This sentence 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.

[For direct response issued policies]

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

[Include for each plan offered by the insurer a chart showing the services, Medicare payments, plan payments, and insured payments using the same language, in the same order, and using uniform layout and format as shown in the charts that follow. An insurer may use additional benefit plan designations on these charts 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 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 $1,340	$0	$1,340 (Part A Deductible)
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	$0	Up to $167.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE Medicare Approved Services			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,340 (Part A Deductible)	$0

61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	$0	Up to $167.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN B

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

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)

Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after —While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $183 of Medicare Approved Amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $183 of Medicare Approved Amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE Medicare Approved Services			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $183 of Medicare Approved Amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
OTHER BENEFITS—NOT COVERED BY MEDICARE			
FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

speech therapy, diagnostic tests, durable medical equipment,			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			
Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
Medicare Approved Services			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

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

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

**This high-deductible plan pays the same benefits as plan F after you have paid a calendar year $2,240 deductible. Benefits from the high-deductible plan F will not begin until out-of-pocket expenses are $2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes Medicare deductibles for part A and part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,240 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $2,240 DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**This high-deductible plan pays the same benefits as plan F after you have paid a calendar year $2,240 deductible. Benefits from the high-deductible plan F will not begin until out-of-pocket expenses are $2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes Medicare deductibles for part A and part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,240 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $2,240 DEDUCTIBLE**, YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such			

as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $183 of Medicare Approved Amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $183 of Medicare Approved Amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			
Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
Medicare Approved Services			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $183 of Medicare Approved Amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN G OR HIGH-DEDUCTIBLE PLAN G
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

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

** This high-deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,240 deductible. Benefits from the high-deductible Plan G will not begin until out-of-pocket expenses are $2,240. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,240 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $2,240 DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

** This high-deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,240 deductible. Benefits from the high-deductible Plan G will not begin until out-of-pocket expenses are $2,240. Out-of-pocket expenses for this deductible include expenses for the Medicare part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,240 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $2,240 DEDUCTIBLE**, YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such			

as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $183 of Medicare Approved Amounts*	$0	$0	$163 (Unless Part B Deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	0%
BLOOD			
First 3 pints	$0	All Costs	$0
Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Unless Part B Deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			
Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
Medicare Approved Services			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Unless Part B Deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $5,240 each calendar year. The amounts that count toward your annual limit are noted with diamonds[1] in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$670 (50% of Part A Deductible)	$670 (50% of Part A Deductible)♦
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $83.75 a day	Up to $83.75 a day♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%♦
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	50% of copayment/ coinsurance	50% of Medicare copayments/ coinsurance♦

***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 $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

First $183 of Medicare Approved Amounts****	$0	$0	$183 (Part B Deductible) ****♦
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%♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $5,240)*
BLOOD			
First 3 pints	$0	50%	50%♦
Next $183 of Medicare Approved Amounts****	$0	$0	$183 (Part B Deductible) ****♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%♦
CLINICAL LABORATORY SERVICES—			
Tests for diagnostic services	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $5,240 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B			
HOME HEALTH CARE			
Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $183 of Medicare Approved Amounts*****	$0	$0	$183 (Part B Deductible)♦
Remainder of Medicare Approved Amounts	80%	10%	10%♦

*****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 $2,620 each calendar year. The amounts that count toward your annual limit are noted with diamonds[1] in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN L

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,005 (75% of Part A Deductible)	$335 (25% of Part A Deductible)♦
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $125.63 a day	Up to $41.88 a day♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%♦
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	75% of copayment/ coinsurance	25% of copayment/ coinsurance♦

***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 $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

First $183 of Medicare Approved Amounts****	$0	$0	$183 (Part B Deductible) ****♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $2,620)*
BLOOD			
First 3 pints	$0	75%	25%♦
Next $183 of Medicare Approved Amounts****	$0	$0	$183 (Part B Deductible)♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—			
Tests for diagnostic services	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $2,620 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B			
HOME HEALTH CARE			
Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $183 of Medicare Approved Amounts*****	$0	$0	$183 (Part B Deductible)♦
Remainder of Medicare Approved Amounts	80%	15%	5%♦

*****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 $1,340	$670 (50% of Part A Deductible)	$670 (50% of Part A Deductible)
61st thru 90th day	All but $335 a day	$335 a day	$0

91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the Additional 365 days	All but $670 a day $0 $0	$670 a day 100% of Medicare Eligible Expenses $0	$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 21st thru 100th day	 All approved amounts All but $167.50 a day	 $0 Up to $167.50 a day	 $0 $0
101st day and after	$0	$0	All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $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 $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $183 (Part B Deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All Costs	$0

Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $183 of Medicare Approved Amounts	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN 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 $1,340	$1,340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN N

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

*Once you have been billed $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
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.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs

BLOOD			
First 3 pints	$0	All Costs	$0
Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			
Tests for diagnostic services	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE			
Medicare Approved Services			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
OTHER BENEFITS—NOT COVERED BY MEDICARE			
FOREIGN TRAVEL—			
Not covered by Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Sec. 3819a. (1) This section applies to all Medicare supplement policies or certificates delivered or issued for delivery with an effective date for coverage on or after June 1, 2010.

(2) An insurance policy must not be titled, advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if the policy does not meet the minimum standards prescribed in this section. These minimum standards are in addition to all other requirements of this chapter. An issuer shall not offer any 1990 plan for sale on or after June 1, 2010. Benefit standards applicable to 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 supplement policies:

(a) A Medicare supplement policy 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 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 supplement policy must not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(c) A Medicare supplement policy must provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

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

(e) Termination of a Medicare supplement policy 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 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 part D benefits will not be considered in determining a continuous loss.

(f) A Medicare supplement policy 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 supplement policy must provide that benefits and premiums under the policy 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, but only if the policyholder or certificate holder notifies the insurer of the assistance within 90 days after the date the individual becomes entitled to the assistance. 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 eligibility, subject to adjustment for paid claims. If a suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance under Medicaid, the policy 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 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. A Medicare supplement policy must provide that benefits and premiums under the policy will be suspended at the request of the policyholder if the policyholder is entitled to benefits under 42 USC 426(b), and is covered under a group health plan as defined in 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 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 supplement policy under this subsection:

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

(b) Reinstituted coverage must be substantially equivalent to coverage in effect before the date of the suspension.

(c) Classification of premiums for reinstituted coverage 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 supplement insurance policy or certificate must not be delivered or issued for delivery in this state if the policy or certificate provides benefits that duplicate benefits provided by Medicare.

(2) Application forms or a supplementary application or other form to be signed by the applicant and agent for Medicare supplement policies, 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, on the date of the application, the applicant has Medicare supplement, Medicare advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any health policy or certificate presently in force:

[STATEMENTS]

(1) You do not need more than 1 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 and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days after becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy, or, if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days after losing Medicaid eligibility. If the Medicare supplement provided coverage for outpatient prescription drugs and you enrolled in 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 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 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 supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy, or if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days after losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in 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 supplement insurance and concerning 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 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 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 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 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 pay your premiums for this Medicare supplement policy?

Yes ____ No ____

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare part B premium?

Yes ____ No ____

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare advantage plan, or a 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 plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes ____ No ____

(c) Was this your first time in this type of Medicare plan?

Yes ____ No ____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes ____ No ____

(4) (a) Do you have another 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 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 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, to the applicant on delivery of the policy or certificate.

(5) On determining that a sale will involve replacement of Medicare supplement coverage, an insurer, other than a direct response insurer or its agent, shall furnish the applicant before issuance or delivery of the Medicare supplement policy the following notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, unless the coverage is sold without an agent, must be provided to the applicant and an additional signed copy 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 supplement coverage. The notice regarding replacement of Medicare supplement coverage 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 supplement coverage or 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 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 supplement, or, if applicable, Medicare advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your 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 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 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 enrolled for benefits under Medicare part B. Each Medicare supplement policy currently available from an insurer 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) 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 in 42 USC 1395ss.

(*ii*) Coverage supplemental to the coverage provided under chapter 55 of title 10 of the United States Code, 10 USC 1071 to 1110b.

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

Sec. 3831. (1) Each insurer offering group expense incurred hospital, medical, or surgical policies or certificates in this state shall make available without restriction, to any person who requests coverage from an insurer and has been insured with an insurer, if the person loses coverage under a group policy after becoming eligible for Medicare, a right of continuation or conversion to 1 of the following Medicare supplement plans that is guaranteed renewable or noncancellable:

(a) A policy form or certificate form that contains the basic core benefits as described in section 3807 or 3807a.

(b) A policy form or certificate form that the insurer has chosen to offer that contains either standardized benefit plan C or standardized benefit plan F. For an individual newly eligible for Medicare after December 31, 2019, any reference to standardized benefit plan C or standardized benefit plan F is deemed a reference to Medicare supplement standardized benefit plan D or Medicare supplement standardized benefit plan G, respectively.

(2) A person who is hospitalized or has been informed by a physician that he or she will require hospitalization within 30 days after the time of application is not entitled to coverage under subsection (1) until the day following the date of discharge. However, if the hospitalized person was insured by the insurer immediately before losing coverage under a group policy after becoming eligible for Medicare, the person is eligible for immediate coverage from the previous insurer under subsection (1). A person is not entitled to a Medicare supplemental policy under subsection (1) unless the person presents satisfactory proof to the insurer that he or she was insured with an insurer subject to this section. A person who wishes coverage under subsection (1) must request coverage within 180 days after losing coverage under a group policy. A person 60 years of age or older who loses coverage under a group policy is entitled to coverage under a Medicare supplemental policy without restriction from the insurer providing the former group coverage, if he or she requests coverage within 90 days before or 90 days after the month he or she becomes eligible for Medicare.

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

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

(5) Notwithstanding the requirements of this section, an insurer offering or renewing group expense incurred hospital, medical, or surgical policies or certificates after June 27, 2005 may comply with the requirement of providing Medicare supplemental coverage to eligible policyholders by utilizing another insurer to write this coverage 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 supplemental coverage.

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

(c) The insurer remains responsible for providing Medicare supplemental coverage to its policyholders 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 must identify the process provided in subdivisions (a) to (c) and must clearly state that the insurer understands that the director may void this arrangement if the affiliate fails to ensure that eligible policyholders are immediately offered Medicare supplemental policies.

(e) If the insurer is unable to meet the requirements of subdivisions (a) to (d), the insurer certifies to the director that it is in the process of discontinuing in this state its offering of individual or group expense incurred hospital, medical, or surgical policies or certificates.

Sec. 3835. (1) An insurer 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 supplement insurance already has health coverage.

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

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

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

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

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

Sec. 3843. (1) A policy or certificate of health insurance issued for delivery in this state to persons eligible for Medicare by reason of age must notify insureds under the policy or certificate that the policy is not a Medicare supplement policy. The notice 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 must be in not less than 12-point type, and must contain the following language:

"This (policy or certificate) is not a Medicare supplement (policy or certificate). It is not designed to fit with Medicare. It may not fit all of the gaps in Medicare and it may duplicate some Medicare benefits. If you are eligible for Medicare, review the 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 supplement policy or certificate.

(b) A disability income policy or certificate.

(c) A single premium nonrenewable policy or certificate.

Sec. 3847. An insurer that provides Medicare supplement insurance coverage in this state shall file with the director for review a copy of any written, radio, or television advertisement for Medicare supplement insurance intended for use in this state at least 30 days before the date the insurer desires to use the advertising. The filing must include a sample or photocopy of all applicable 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.

This act is ordered to take immediate effect.

Clerk of the House of Representatives

Secretary of the Senate

Approved .....

Governor