

# SENATE BILL No. 743

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

A bill to amend 1956 PA 218, entitled  
"The insurance code of 1956,"  
by amending sections 3801, 3803, 3807, 3809, 3811, 3815, 3819,  
3831, and 3839 (MCL 500.3801, 500.3803, 500.3807, 500.3809,  
500.3811, 500.3815, 500.3819, 500.3831, and 500.3839), sections  
3801, 3807, 3809, 3811, 3815, 3819, 3831, and 3839 as amended by  
2006 PA 462 and section 3803 as added by 1992 PA 84, and by  
adding sections 3807a, 3809a, 3811a, and 3819a.

## THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1       Sec. 3801. As used in this chapter:

2       (a) "Applicant" means:

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

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

1 the proposed certificate holder.

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

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

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

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

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

17 (i) A group health plan.

18 (ii) Health insurance coverage.

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

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

22 (v) Chapter 55 of title 10 of the United States Code, 10 USC  
23 1071 to 1110.

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

26 (vii) A state health benefits risk pool.

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

1 the United States Code, 5 USC 8901 to 8914.

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

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

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

10 (h) "Employee welfare benefit plan" means a plan, fund, or  
11 program of employee benefits as defined in section 3 of subtitle  
12 A of title I of the employee retirement income security act of  
13 1974, 29 USC 1002.

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

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

24 (k) "Medicaid" means title XIX of the social security act,  
25 42 USC 1396 to 1396v.

26 (l) "Medicare" means title XVIII of the social security act,  
27 42 USC 1395 to 1395ggg.

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

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

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

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

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

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

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

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

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

13 (R) "1990 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN",  
14 "1990 STANDARDIZED BENEFIT PLAN", OR "1990 PLAN" MEANS A GROUP OR  
15 INDIVIDUAL POLICY OF MEDICARE SUPPLEMENT INSURANCE ISSUED ON OR  
16 AFTER JUNE 2, 1992 WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO  
17 JUNE 1, 2010 AND INCLUDES MEDICARE SUPPLEMENT INSURANCE POLICIES  
18 AND CERTIFICATES RENEWED ON OR AFTER THAT DATE WHICH ARE NOT  
19 REPLACED BY THE ISSUER AT THE REQUEST OF THE INSURED.

20 (S) "2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN",  
21 "2010 STANDARDIZED BENEFIT PLAN", OR "2010 PLAN" MEANS A GROUP OR  
22 INDIVIDUAL POLICY OF MEDICARE SUPPLEMENT INSURANCE WITH AN  
23 EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



1 subparagraph (x).

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

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

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

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

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

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

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

23 SEC. 3807A. (1) THIS SECTION APPLIES TO ALL MEDICARE  
24 SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR ISSUED FOR  
25 DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1,  
26 2010.

27 (2) EVERY INSURER ISSUING A MEDICARE SUPPLEMENT INSURANCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 medicare approved home care plan of treatment.

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

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

5 (iv) Seven visits in any 1 week.

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

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

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

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

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

27 (2) Reimbursement for the preventive screening tests and

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

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

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

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

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

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

25 **(4) THIS SECTION APPLIES TO MEDICARE SUPPLEMENT POLICIES OR**  
26 **CERTIFICATES DELIVERED OR ISSUED FOR DELIVERY ON OR AFTER JUNE 2,**  
27 **1992 WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010.**

1 SEC. 3809A. (1) THIS SECTION APPLIES TO ALL MEDICARE  
2 SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR ISSUED FOR  
3 DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1,  
4 2010.

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

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

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

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

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

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



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

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

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

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

1 arrangement, and overall content of a benefit.

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

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

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

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

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

20 (d) A standardized medicare supplement benefit plan D shall  
21 include only the following: the core benefits as defined in  
22 section 3807, the medicare part A deductible, skilled nursing  
23 facility care, medically necessary emergency care in a foreign  
24 country, and the at-home recovery benefit as defined in section  
25 3809(1)(a), (b), (h), and (j).

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

1 section 3807, the medicare part A deductible, skilled nursing  
2 facility care, medically necessary emergency care in a foreign  
3 country, and preventive medical care as defined in section  
4 3809(1)(a), (b), (h), and (i).

5 (f) A standardized medicare supplement benefit plan F shall  
6 include only the following: the core benefits as defined in  
7 section 3807, the medicare part A deductible, skilled nursing  
8 facility care, medicare part B deductible, 100% of the medicare  
9 part B excess charges, and medically necessary emergency care in  
10 a foreign country as defined in section 3809(1)(a), (b), (c),  
11 (e), and (h). A standardized medicare supplement plan F high  
12 deductible shall include only the following: 100% of covered  
13 expenses following the payment of the annual high deductible plan  
14 F deductible. The covered expenses include the core benefits as  
15 defined in section 3807, plus the medicare part A deductible,  
16 skilled nursing facility care, the medicare part B deductible,  
17 100% of the medicare part B excess charges, and medically  
18 necessary emergency care in a foreign country as defined in  
19 section 3809(1)(a), (b), (c), (e), and (h). The annual high  
20 deductible plan F deductible shall consist of out-of-pocket  
21 expenses, other than premiums, for services covered by the  
22 medicare supplement plan F policy, and shall be in addition to  
23 any other specific benefit deductibles. The annual high  
24 deductible plan F deductible is \$1,790.00 for calendar year 2006,  
25 and the secretary shall adjust it annually thereafter to reflect  
26 the change in the consumer price index for all urban consumers  
27 for the 12-month period ending with August of the preceding year,

1 rounded to the nearest multiple of \$10.00.

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

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

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

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

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

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

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

5 (6) THIS SECTION APPLIES TO MEDICARE SUPPLEMENT POLICIES OR  
6 CERTIFICATES DELIVERED OR ISSUED FOR DELIVERY ON OR AFTER JUNE 2,  
7 1992 WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010.

8 SEC. 3811A. (1) THIS SECTION APPLIES TO ALL MEDICARE  
9 SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR ISSUED FOR  
10 DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1,  
11 2010.

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

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

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

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

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

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

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

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

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

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

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

3 (E) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN F SHALL  
4 INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN  
5 SECTION 3807A, 100% OF THE MEDICARE PART A DEDUCTIBLE, SKILLED  
6 NURSING FACILITY CARE, 100% OF THE MEDICARE PART B DEDUCTIBLE,  
7 100% OF THE MEDICARE PART B EXCESS CHARGES, AND MEDICALLY  
8 NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY AS DEFINED IN  
9 SECTION 3809(2)(A), (C), (E), AND (F). A STANDARDIZED MEDICARE  
10 SUPPLEMENT PLAN F HIGH DEDUCTIBLE SHALL INCLUDE ONLY THE  
11 FOLLOWING: 100% OF COVERED EXPENSES FOLLOWING THE PAYMENT OF THE  
12 ANNUAL HIGH DEDUCTIBLE PLAN F DEDUCTIBLE. THE COVERED EXPENSES  
13 INCLUDE THE CORE BENEFITS AS DEFINED IN SECTION 3807A, PLUS 100%  
14 OF THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACILITY CARE,  
15 100% OF THE MEDICARE PART B DEDUCTIBLE, 100% OF THE MEDICARE PART  
16 B EXCESS CHARGES, AND MEDICALLY NECESSARY EMERGENCY CARE IN A  
17 FOREIGN COUNTRY AS DEFINED IN SECTION 3809(2)(A), (C), (D), (E),  
18 AND (F). THE ANNUAL HIGH DEDUCTIBLE PLAN F DEDUCTIBLE SHALL  
19 CONSIST OF OUT-OF-POCKET EXPENSES, OTHER THAN PREMIUMS, FOR  
20 SERVICES COVERED BY THE MEDICARE SUPPLEMENT PLAN F POLICY, AND  
21 SHALL BE IN ADDITION TO ANY OTHER SPECIFIC BENEFIT DEDUCTIBLES.  
22 THE ANNUAL HIGH DEDUCTIBLE PLAN F DEDUCTIBLE IS \$1,500.00 FOR  
23 CALENDAR YEAR 1999, AND THE SECRETARY SHALL ADJUST IT ANNUALLY  
24 THEREAFTER TO REFLECT THE CHANGE IN THE CONSUMER PRICE INDEX FOR  
25 ALL URBAN CONSUMERS FOR THE 12-MONTH PERIOD ENDING WITH AUGUST OF  
26 THE PRECEDING YEAR, ROUNDED TO THE NEAREST MULTIPLE OF \$10.00.

27 (F) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN G SHALL



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 (a) A cover page.

24 (b) Premium information.

25 (c) Disclosure pages.

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

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

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

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

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

1 commissioner:

2 \_\_\_\_\_ (Insurer Name)

3 \_\_\_\_\_ Medicare Supplement Coverage

4 \_\_\_\_\_ Outline of Medicare Supplement Coverage Cover Page:

5 Benefit Plan(s) \_\_\_\_\_ [insert letter(s) of plan(s) being offered]

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

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

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

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

16 Blood: First three pints of blood each year.

17		A	B	C	D	E	F F*	G	H	I	J J*
18	Basic Benefits	x	x	x	x	x	x	x	x	x	x
19	Skilled Nursing										
20	Co-Insurance			x	x	x	x	x	x	x	x
21	Part A Deductible		x	x	x	x	x	x	x	x	x
22	Part B Deductible			x			x				x
23	Part B Excess						x	x		x	x
24							100%	80%		100%	100%
25	Foreign Travel										
26	Emergency			x	x	x	x	x	x	x	x
27	At Home Recovery				x			x		x	x

1										
2										
3										
4	<del>Preventive Care not covered by Medicare</del>					<del>x</del>				<del>x</del>

5 ~~\_\_\_\_\_ [COMPANY NAME]~~

6 ~~\_\_\_\_\_ Outline of Medicare Supplement Coverage \_\_\_\_\_ Cover Page 2~~

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

10		<del>K**</del>	<del>L**</del>
11	<del>Basic Benefits</del>	<del>100% of Part A</del>	<del>100% of Part A</del>
12		<del>hospitalization</del>	<del>hospitalization</del>
13		<del>coinsurance plus</del>	<del>coinsurance plus</del>
14		<del>coverage for 365 days</del>	<del>coverage for 365 days</del>
15		<del>after Medicare</del>	<del>after Medicare</del>
16		<del>benefits end</del>	<del>benefits end</del>
17		<del>50% Hospice cost-</del>	<del>75% Hospice cost-</del>
18		<del>sharing</del>	<del>sharing</del>
19		<del>50% of Medicare-</del>	<del>75% of Medicare-</del>
20		<del>eligible</del>	<del>eligible</del>
21		<del>expenses for the</del>	<del>expenses for the</del>
22		<del>first three pints</del>	<del>first three pints</del>
23		<del>of blood</del>	<del>of blood</del>
24		<del>50% Part B</del>	<del>75% Part B</del>
25		<del>coinsurance, except</del>	<del>coinsurance, except</del>
26		<del>100% coinsurance for</del>	<del>100% coinsurance for</del>
27		<del>Part B preventive</del>	<del>Part B preventive</del>

1		<del>services</del>	<del>services</del>
2	<del>Skilled Nursing</del>	<del>50% skilled nursing</del>	<del>75% skilled nursing</del>
3	<del>Coinsurance</del>	<del>facility coinsurance</del>	<del>facility coinsurance</del>
4	<del>Part A Deductible</del>	<del>50% Part A deductible</del>	<del>75% Part A deductible</del>
5	<del>Part B Deductible</del>		
6	<del>Part B Excess (100%)</del>		
7	<del>Foreign Travel</del>		
8	<del>Emergency</del>		
9	<del>At Home Recovery</del>		
10	<del>Preventive Care not</del>		
11	<del>covered by Medicare</del>		
12		<del>\$4,000 out of pocket</del>	<del>\$2,000 out of pocket</del>
13		<del>Annual Limit***</del>	<del>Annual Limit***</del>

14 ~~\*Plans F and J also have an option called a high deductible plan F~~  
 15 ~~and a high deductible plan J. These high deductible plans pay the~~  
 16 ~~same benefits as Plans F and J after one has paid a calendar year~~  
 17 ~~(\$1,790) deductible. Benefits from high deductible Plans F and J~~  
 18 ~~will not begin until out of pocket expenses exceed (\$1,790). Out-~~  
 19 ~~of pocket expenses for this deductible are expenses that would~~  
 20 ~~ordinarily be paid by the policy. These expenses include the~~  
 21 ~~Medicare deductibles for Part A and Part B, but do not include the~~  
 22 ~~plan's separate foreign travel emergency deductible.~~

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

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



~~1 calendar year. The out of pocket annual limit does NOT include~~  
~~2 charges from your provider that exceed Medicare approved amounts,~~  
~~3 called "Excess Charges". You will be responsible for paying excess~~  
~~4 charges.~~

~~5 \*\*\*The out of pocket annual limit will increase each year for~~  
~~6 inflation.~~

~~7 See Outlines of Coverage for details and exceptions.~~

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

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

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

15           **BASIC BENEFITS:**

16           **HOSPITALIZATION: PART A COINSURANCE PLUS COVERAGE FOR 365**  
17           **ADDITIONAL DAYS AFTER MEDICARE BENEFITS END.**

18           **MEDICAL EXPENSES: PART B COINSURANCE (GENERALLY 20% OF**  
19           **MEDICARE-APPROVED EXPENSES) OR COPAYMENTS FOR HOSPITAL**  
20           **OUTPATIENT SERVICES. PLANS K, L, AND N REQUIRE INSURED**  
21           **TO PAY A PORTION OF PART B COINSURANCE OR COPAYMENTS.**

22           **BLOOD: FIRST THREE PINTS OF BLOOD EACH YEAR.**

23           **HOSPICE: PART A COINSURANCE**

1	A	B	C	D	F   F*	G
2	BASIC,	BASIC,	BASIC,	BASIC,	BASIC,	BASIC,
3	INCLUDING	INCLUDING	INCLUDING	INCLUDING	INCLUDING	INCLUDING
4	100% PART	100% PART	100% PART	100% PART	100% PART	100% PART
5	B COIN-	B COINSUR-	B COINSUR-	B COINSUR-	B COINSUR-	B COINSUR-
6	SURANCE	ANCE	ANCE	ANCE	ANCE	ANCE
7			SKILLED	SKILLED	SKILLED	SKILLED
8			NURSING	NURSING	NURSING	NURSING
9			FACILITY	FACILITY	FACILITY	FACILITY
10			COINSUR-	COINSUR-	COINSUR-	COINSUR-
11			ANCE	ANCE	ANCE	ANCE
12		PART A	PART A	PART A	PART A	PART A
13		DEDUCTIBLE	DEDUCTIBLE	DEDUCTIBLE	DEDUCTIBLE	DEDUCTIBLE
14			PART B		PART B	
15			DEDUCTIBLE		DEDUCTIBLE	
16					PART B	PART B
17					EXCESS	EXCESS
18					(100%)	(100%)
19			FOREIGN	FOREIGN	FOREIGN	FOREIGN
20			TRAVEL	TRAVEL	TRAVEL	TRAVEL
21			EMERGENCY	EMERGENCY	EMERGENCY	EMERGENCY

  

22	K	L	M	N
23	HOSPITALIZATION	HOSPITALIZATION	BASIC,	BASIC, INCLUD-
24	AND PREVENTIVE	AND PREVENTIVE	INCLUDING 100%	ING 100% PART B
25	CARE PAID AT	CARE PAID AT	PART B	COINSURANCE,
26	100%; OTHER	100%; OTHER	COINSURANCE	EXCEPT UP TO
27	BASIC BENEFITS	BASIC BENEFITS		\$20 COPAYMENT
28	PAID AT 50%	PAID AT 75%		FOR OFFICE
29				VISIT, AND UP
30				TO \$50 COPAY-

1				MENT FOR ER
2	50% SKILLED	75% SKILLED	SKILLED	SKILLED
3	NURSING	NURSING	NURSING	NURSING
4	FACILITY	FACILITY	FACILITY	FACILITY
5	COINSURANCE	COINSURANCE	COINSURANCE	COINSURANCE
6	50% PART A	75% PART A	50% PART A	PART A
7	DEDUCTIBLE	DEDUCTIBLE	DEDUCTIBLE	DEDUCTIBLE
8				
9				
10				
11				
12				
13			FOREIGN	FOREIGN
14			TRAVEL	TRAVEL
15			EMERGENCY	EMERGENCY
16	OUT-OF-POCKET	OUT-OF-POCKET		
17	LIMIT \$4,140;	LIMIT \$2,070;		
18	PAID AT 100%	PAID AT 100%		
19	AFTER LIMIT	AFTER LIMIT		
20	REACHED	REACHED		

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

1                                   PREMIUM INFORMATION

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

6                                   DISCLOSURES

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

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

14                                  READ YOUR POLICY VERY CAREFULLY

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

19                                  RIGHT TO RETURN POLICY

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

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

4 POLICY REPLACEMENT

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

8 NOTICE

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

10 [For agent issued policies]

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

13 [For direct response issued policies]

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

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

18 COMPLETE ANSWERS ARE VERY IMPORTANT

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

1 guaranteed issue, this paragraph need not appear.]

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

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

15 PLAN A

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

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

21	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
22	HOSPITALIZATION*			
23	Semiprivate room and			
24	board, general nursing			
25	and miscellaneous			

1	services and supplies			
2	First 60 days	All but <del>\$952</del>	\$0	<del>\$952</del> <b>\$992</b>
3		<b>\$992</b>		(Part A
4				Deductible)
5	61st thru 90th day	All but <del>\$238</del>	<del>\$238</del> <b>\$248</b>	\$0
6		<b>\$248</b> a day	a day	
7	91st day and after:			
8	—While using 60			
9	lifetime reserve days	All but <del>\$476</del>	<del>\$476</del> <b>\$496</b>	\$0
10		<b>\$496</b> a day	a day	
11	—Once lifetime reserve			
12	days are used:			
13	—Additional 365 days	\$0	100% of	\$0**
14			Medicare	
15			Eligible	
16			Expenses	
17	—Beyond the			
18	Additional 365 days	\$0	\$0	All Costs
19	SKILLED NURSING FACILITY			
20	CARE*			
21	You must meet Medicare's			
22	requirements, including			
23	having been in a hospital			
24	for at least 3 days and			
25	entered a Medicare-			
26	approved facility within			
27	30 days after leaving the			
28	hospital			
29	First 20 days	All approved		
30		amounts	\$0	\$0
31	21st thru 100th day	All but <del>\$119</del>	\$0	Up to <del>\$119</del>

1		\$124 a day		\$124 a day
2	101st day and after	\$0	\$0	All costs
3	BLOOD			
4	First 3 pints	\$0	3 pints	\$0
5	Additional amounts	100%	\$0	\$0
6	HOSPICE CARE			
7	<del>Available as long as your</del>	All but very	<del>\$0</del>	Balance\$0
8	<del>doctor certifies you are</del>	limited	<b>MEDICARE</b>	
9	<del>terminally ill and you</del>	<b>COPAYMENT/</b>	<b>COPAYMENT/</b>	
10	<del>elect to receive these</del>	coinsurance	<b>COINSURANCE</b>	
11	<b>SERVICES YOU MUST MEET</b>	for outpatient		
12	<b>MEDICARE'S REQUIREMENTS,</b>	drugs and		
13	<b>INCLUDING A DOCTOR'S</b>	inpatient		
14	<b>CERTIFICATION OF TERMINAL</b>	respite care		
15	<b>ILLNESS</b>			

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

23 PLAN A

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

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



1

2	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
3	MEDICAL EXPENSES—			
4	In or out of the hospital			
5	and outpatient hospital			
6	treatment, such as			
7	Physician's services,			
8	inpatient and outpatient			
9	medical and surgical			
10	services and supplies,			
11	physical and speech			
12	therapy, diagnostic			
13	tests, durable medical			
14	equipment,			
15	First <del>\$124</del> <b>\$131</b> of			
16	Medicare Approved	\$0	\$0	<del>\$124</del> <b>\$131</b>
17	Amounts*			(Part B
18				Deductible)
19	Remainder of Medicare			
20	Approved Amounts	80%	20%	\$0
21	Part B Excess Charges			
22	(Above Medicare			
23	Approved Amounts)	\$0	\$0	All Costs
24	BLOOD			
25	First 3 pints	\$0	All Costs	\$0
26	Next <del>\$124</del> <b>\$131</b> of			
27	Medicare	\$0	\$0	<del>\$124</del> <b>\$131</b>
28	Approved Amounts*			(Part B
29				Deductible)

1	Remainder of Medicare			
2	Approved Amounts	80%	20%	\$0
3	CLINICAL LABORATORY			
4	SERVICES—			
5	Tests for			
6	diagnostic services	100%	\$0	\$0

7

## PARTS A &amp; B

8	HOME HEALTH CARE			
9	Medicare Approved			
10	Services			
11	—Medically necessary			
12	skilled care services			
13	and medical supplies	100%	\$0	\$0
14	—Durable medical			
15	equipment			
16	First <del>\$124</del> \$131 of			
17	Medicare	\$0	\$0	<del>\$124</del> —\$131
18	Approved Amounts*			(Part B
19				Deductible)
20	Remainder of Medicare			
21	Approved Amounts	80%	20%	\$0

22

## PLAN B

23

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

24

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

25

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

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

3	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
4	HOSPITALIZATION*			
5	Semiprivate room and			
6	board, general nursing			
7	and miscellaneous			
8	services and supplies			
9	First 60 days	All but <del>\$952</del>	<del>\$952</del> <b>\$992</b>	\$0
10		<b>\$992</b>	(Part A	
11			Deductible)	
12	61st thru 90th day	All but <del>\$238</del>	<del>\$238</del> <b>\$248</b>	\$0
13		<b>\$248</b> a day	a day	
14	91st day and after			
15	—While using 60			
16	lifetime reserve days	All but <del>\$476</del>	<del>\$476</del> <b>\$496</b>	\$0
17		<b>\$496</b> a day	a day	
18	—Once lifetime reserve			
19	days are used:			
20	—Additional 365 days	\$0	100% of	\$0**
21			Medicare	
22			Eligible	
23			Expenses	
24	—Beyond the			
25	Additional 365 days	\$0	\$0	All Costs
26	SKILLED NURSING FACILITY			
27	CARE*			
28	You must meet Medicare's			
29	requirements, including			

1	having been in a hospital			
2	for at least 3 days and			
3	entered a Medicare-			
4	approved facility within			
5	30 days after leaving the			
6	hospital			
7	First 20 days	All approved		
8		amounts	\$0	\$0
9	21st thru 100th day	All but <del>\$119</del>	\$0	Up to <del>\$119</del>
10		<b>\$124</b> a day		<b>\$124</b> a day
11	101st day and after	\$0	\$0	All costs
12	BLOOD			
13	First 3 pints	\$0	3 pints	\$0
14	Additional amounts	100%	\$0	\$0
15	HOSPICE CARE			
16	<del>Available as long as your</del>	All but very	<del>\$0</del>	Balance
17	<del>doctor certifies you are</del>	limited	<b>MEDICARE</b>	<b>\$0</b>
18	<del>terminally ill and you</del>	<b>COPAYMENT/</b>	<b>COPAYMENT/</b>	
19	<del>elect to receive these</del>	coinsurance	<b>COINSURANCE</b>	
20	<del>services</del> <b>YOU MUST MEET</b>	for outpatient		
21	<b>MEDICARE'S REQUIREMENTS,</b>	drugs and		
22	<b>INCLUDING A DOCTOR'S</b>	inpatient		
23	<b>CERTIFICATION OF</b>	respite care		
24	<b>TERMINAL ILLNESS</b>			

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

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

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

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

8	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
9	MEDICAL EXPENSES—			
10	In or out of the hospital			
11	and outpatient hospital			
12	treatment, such as			
13	Physician's services,			
14	inpatient and outpatient			
15	medical and surgical			
16	services and supplies,			
17	physical and speech			
18	therapy, diagnostic			
19	tests, durable medical			
20	equipment,			
21	First <del>\$124</del> <b>\$131</b> of			
22	Medicare Approved	\$0	\$0	<del>\$124</del> <b>\$131</b>
23	Amounts*			(Part B
24				Deductible)
25	Remainder of Medicare			
26	Approved Amounts	80%	20%	\$0
27	Part B Excess Charges			

1	(Above Medicare			
2	Approved Amounts)	\$0	\$0	All Costs
3	BLOOD			
4	First 3 pints	\$0	All Costs	\$0
5	Next <del>\$124</del> \$131 of Medicare			
6	Approved Amounts*	\$0	\$0	<del>\$124</del> \$131
7				(Part B
8	Remainder of Medicare			Deductible)
9	Approved Amounts	80%	20%	\$0
10	CLINICAL LABORATORY			
11	SERVICES—			
12	Tests for			
13	diagnostic services	100%	\$0	\$0

14 PARTS A & B

15	HOME HEALTH CARE			
16	Medicare Approved			
17	Services			
18	—Medically necessary			
19	skilled care services			
20	and medical supplies	100%	\$0	\$0
21	—Durable medical			
22	equipment			
23	First <del>\$124</del> \$131 of			
24	Medicare			
25	Approved Amounts*	\$0	\$0	<del>\$124</del> \$131
26				(Part B
27				Deductible)
28	Remainder of Medicare			

1	Approved Amounts	80%	20%	\$0
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2 PLAN C

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

4 \*A benefit period begins on the first day you receive

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

6 been out of the hospital and have not received skilled care in

7 any other facility for 60 days in a row.

8	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
9	HOSPITALIZATION*			
10	Semiprivate room and			
11	board, general nursing			
12	and miscellaneous			
13	services and supplies			
14	First 60 days	All but <del>\$952</del>	<del>\$952</del> <b>\$992</b>	\$0
15		<b>\$992</b>	(Part A	
16			Deductible)	
17	61st thru 90th day	All but <del>\$238</del>	<del>\$238</del> <b>\$248</b>	\$0
18		<b>\$248</b> a day	a day	
19	91st day and after			
20	—While using 60			
21	lifetime reserve days	All but <del>\$476</del>	<del>\$476</del> <b>\$496</b>	\$0
22		<b>\$496</b> a day	a day	
23	—Once lifetime reserve			
24	days are used:			
25	—Additional 365 days	\$0	100% of	\$0**
26			Medicare	

1			Eligible	
2			Expenses	
3	—Beyond the			
4	Additional 365 days	\$0	\$0	All Costs
5	SKILLED NURSING FACILITY			
6	CARE*			
7	You must meet Medicare's			
8	requirements, including			
9	having been in a hospital			
10	for at least 3 days and			
11	entered a Medicare-			
12	approved facility within			
13	30 days after leaving the			
14	hospital			
15	First 20 days	All approved		
16		amounts	\$0	\$0
17	21st thru 100th day	All but <del>\$119</del>	Up to <del>\$119</del>	\$0
18		<b>\$124</b> a day	<b>\$124</b> a day	
19	101st day and after	\$0	\$0	All costs
20	BLOOD			
21	First 3 pints	\$0	3 pints	\$0
22	Additional amounts	100%	\$0	\$0
23	HOSPICE CARE			
24	<del>Available as long as your</del>	All but very	<del>\$0</del>	<del>Balance</del> <b>\$0</b>
25	<del>doctor certifies you are</del>	limited	<b>MEDICARE</b>	
26	<del>terminally ill and you</del>	<b>COPAYMENT/</b>	<b>COPAYMENT/</b>	
27	<del>elect to receive these</del>	coinsurance	<b>COINSURANCE</b>	
28	<del>services</del> <b>YOU MUST MEET</b>	for outpatient		
29	<b>MEDICARE'S REQUIREMENTS,</b>	drugs and		
30	<b>INCLUDING A DOCTOR'S</b>	inpatient		
31	<b>CERTIFICATION OF</b>	respite care		



## 1 | TERMINAL ILLNESS

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

## PLAN C

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

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

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

1	equipment,			
2	First <del>\$124</del> <b>\$131</b> of			
3	Medicare Approved	\$0	<del>\$124</del> <b>\$131</b>	\$0
4	Amounts*		(Part B	
5			Deductible)	
6	Remainder of Medicare			
7	Approved Amounts	80%	20%	\$0
8	Part B Excess Charges			
9	(Above Medicare			
10	Approved Amounts)	\$0	\$0	All Costs
11	BLOOD			
12	First 3 pints	\$0	All Costs	\$0
13	Next <del>\$124</del> <b>\$131</b> of Medicare			
14	Approved Amounts*	\$0	<del>\$124</del> <b>\$131</b>	\$0
15			(Part B	
16			Deductible)	
17	Remainder of Medicare			
18	Approved Amounts	80%	20%	\$0
19	CLINICAL LABORATORY			
20	SERVICES—			
21	Tests for			
22	diagnostic services	100%	\$0	\$0

23 PARTS A & B

24	HOME HEALTH CARE			
25	Medicare Approved			
26	Services			
27	—Medically necessary			

1	skilled care services			
2	and medical supplies	100%	\$0	\$0
3	—Durable medical			
4	equipment			
5	First <del>\$124</del> \$131 of			
6	Medicare Approved	\$0	<del>\$124</del> \$131	\$0
7	Amounts*		(Part B	
8			Deductible)	
9	Remainder of Medicare			
10	Approved Amounts	80%	20%	\$0

11 OTHER BENEFITS—NOT COVERED BY MEDICARE

12	FOREIGN TRAVEL—			
13	Not covered by Medicare			
14	Medically necessary			
15	emergency care services			
16	beginning during the			
17	first 60 days of each			
18	trip outside the USA			
19	First \$250 each			
20	calendar year	\$0	\$0	\$250
21	Remainder of charges	\$0	80% to a	20% and
22			lifetime	amounts
23			maximum	over the
24			benefit	\$50,000
25			of \$50,000	lifetime
26				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 <del>\$952</del> <b>\$992</b>	<del>\$952</del> <b>\$992</b> (Part A Deductible)	\$0
61st thru 90th day	All but <del>\$238</del> <b>\$248</b> a day	<del>\$238</del> <b>\$248</b> a day	\$0
91st day and after			
—While using 60 lifetime reserve days	All but <del>\$476</del> <b>\$496</b> a day	<del>\$476</del> <b>\$496</b> a day	\$0
—Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
—Beyond the			

1	Additional 365 days	\$0	\$0	All Costs
2	SKILLED NURSING FACILITY			
3	CARE*			
4	You must meet Medicare's			
5	requirements, including			
6	having been in a hospital			
7	for at least 3 days and			
8	entered a Medicare-			
9	approved facility within			
10	30 days after leaving the			
11	hospital			
12	First 20 days	All approved		
13		amounts	\$0	\$0
14	21st thru 100th day	All but <del>\$119</del>	Up to <del>\$119</del>	\$0
15		<b>\$124</b> a day	<b>\$124</b> a day	
16	101st day and after	\$0	\$0	All costs
17	BLOOD			
18	First 3 pints	\$0	3 pints	\$0
19	Additional amounts	100%	\$0	\$0
20	HOSPICE CARE			
21	<del>Available as long as your</del>	All but very	<del>\$0</del> <b>MEDICARE</b>	Balancee <b>\$0</b>
22	<del>doctor certifies you are</del>	limited	<b>COPAYMENT/</b>	
23	<del>terminally ill and you</del>	<b>COPAYMENT/</b>	<b>COINSURANCE</b>	
24	<del>elect to receive these</del>	coinsurance		
25	<del>services</del> <b>YOU MUST MEET</b>	for outpatient		
26	<b>MEDICARE'S REQUIREMENTS,</b>	drugs and		
27	<b>INCLUDING A DOCTOR'S</b>	inpatient		
28	<b>CERTIFICATION OF</b>	respite care		
29	<b>TERMINAL ILLNESS</b>			

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

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

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

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

12	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
13	MEDICAL EXPENSES—			
14	In or out of the hospital			
15	and outpatient hospital			
16	treatment, such as			
17	Physician's services,			
18	inpatient and outpatient			
19	medical and surgical			
20	services and supplies,			
21	physical and speech			
22	therapy, diagnostic			
23	tests, durable medical			
24	equipment,			
25	First <del>\$124</del> \$131 of			
26	Medicare Approved	\$0	\$0	<del>\$124</del> \$131

1	Amounts*			(Part B
2				Deductible)
3	Remainder of Medicare			
4	Approved Amounts	80%	20%	\$0
5	Part B Excess Charges			
6	(Above Medicare			
7	Approved Amounts)	\$0	\$0	All Costs
8	BLOOD			
9	First 3 pints	\$0	All Costs	\$0
10	Next <del>\$124</del> \$131 of Medicare			
11	Approved Amounts*	\$0	\$0	<del>\$124</del> \$131
12				(Part B
13				Deductible)
14	Remainder of Medicare			
15	Approved Amounts	80%	20%	\$0
16	CLINICAL LABORATORY			
17	SERVICES—			
18	Tests for			
19	diagnostic services	100%	\$0	\$0

20

## PARTS A &amp; B

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

1	equipment			
2	First <del>\$124</del> <b>\$131</b> of			
3	Medicare Approved	\$0	\$0	<del>\$124</del> <b>\$131</b>
4	Amounts*			(Part B
5				Deductible)
6	Remainder of Medicare			
7	Approved Amounts	80%	20%	\$0
8	<del>AT HOME RECOVERY</del>			
9	<del>SERVICES—</del>			
10	<del>Not covered by Medicare</del>			
11	<del>Home care certified by</del>			
12	<del>your doctor, for personal</del>			
13	<del>care during recovery from</del>			
14	<del>an injury or sickness for</del>			
15	<del>which Medicare approved a</del>			
16	<del>Home Care Treatment Plan</del>			
17	<del>Benefit for each visit</del>	<del>\$0</del>	Actual	
18			Charges to	
19			<del>\$40 a visit</del>	Balance
20	<del>Number of visits</del>			
21	<del>covered (must be</del>			
22	<del>received within 8</del>			
23	<del>weeks of last</del>			
24	<del>Medicare Approved</del>			
25	<del>visit)</del>	<del>\$0</del>	Up to the	
26			number of	
27			Medicare	
28			Approved	
29			visits, not	
30			to exceed 7	
31			each week	



1	<del>Calendar year maximum</del>	<del>\$0</del>	<del>\$1,600</del>	
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2 OTHER BENEFITS—NOT COVERED BY MEDICARE

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

18 ~~PLAN E~~

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

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

1	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
2	HOSPITALIZATION*			
3	Semiprivate room and			
4	board, general nursing			
5	and miscellaneous			
6	services and supplies			
7	First 60 days	All but \$952	\$952	\$0
8			(Part A	
9			Deductible)	
10	61st thru 90th day	All but \$238	\$238	\$0
11		a day	a day	
12	91st day and after			
13	While using 60			
14	lifetime reserve days	All but \$476	\$476	\$0
15		a day	a day	
16	Once lifetime reserve			
17	days are used:			
18	Additional 365 days	\$0	100% of	\$0
19			Medicare	
20			Eligible	
21			Expenses	
22	Beyond the			
23	Additional 365 days	\$0	\$0	All Costs
24	SKILLED NURSING FACILITY			
25	CARE*			
26	You must meet Medicare's			
27	requirements, including			
28	having been in a hospital			
29	for at least 3 days and			
30	entered a Medicare-			
31	approved facility within			

1	<del>30 days after leaving the</del>			
2	<del>hospital</del>			
3	<del>First 20 days</del>	<del>All approved</del>		
4		<del>amounts</del>	<del>\$0</del>	<del>\$0</del>
5	<del>21st thru 100th day</del>	<del>All but \$119</del>	<del>Up to \$119</del>	<del>\$0</del>
6		<del>a day</del>	<del>a day</del>	
7	<del>101st day and after</del>	<del>\$0</del>	<del>\$0</del>	<del>All costs</del>
8	<del>BLOOD</del>			
9	<del>First 3 pints</del>	<del>\$0</del>	<del>3 pints</del>	<del>\$0</del>
10	<del>Additional amounts</del>	<del>100%</del>	<del>\$0</del>	<del>\$0</del>
11	<del>HOSPICE CARE</del>			
12	<del>Available as long as your</del>	<del>All but very</del>	<del>\$0</del>	<del>Balance</del>
13	<del>doctor certifies you are</del>	<del>limited</del>		
14	<del>terminally ill and you</del>	<del>coinsurance</del>		
15	<del>elect to receive these</del>	<del>for outpatient</del>		
16	<del>services</del>	<del>drugs and</del>		
17		<del>inpatient</del>		
18		<del>respite care</del>		

19 ~~PLAN E~~

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

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

24	<del>SERVICES</del>	<del>MEDICARE PAYS</del>	<del>PLAN PAYS</del>	<del>YOU PAY</del>
25	<del>MEDICAL EXPENSES—</del>			
26	<del>In or out of the hospital</del>			
27	<del>and outpatient hospital</del>			

1	<del>treatment, such as</del>			
2	<del>Physician's services,</del>			
3	<del>inpatient and outpatient</del>			
4	<del>medical and surgical</del>			
5	<del>services and supplies,</del>			
6	<del>physical and speech</del>			
7	<del>therapy, diagnostic</del>			
8	<del>tests, durable medical</del>			
9	<del>equipment,</del>			
10	<del>First \$124 of Medicare</del>			
11	<del>Approved Amounts*</del>	<del>\$0</del>	<del>\$0</del>	<del>\$124</del>
12				<del>(Part B</del>
13				<del>Deductible)</del>
14	<del>Remainder of Medicare</del>			
15	<del>Approved Amounts</del>	<del>80%</del>	<del>20%</del>	<del>\$0</del>
16	<del>Part B Excess Charges</del>			
17	<del>(Above Medicare</del>			
18	<del>Approved Amounts)</del>	<del>\$0</del>	<del>\$0</del>	<del>All Costs</del>
19	<del>BLOOD</del>			
20	<del>First 3 pints</del>	<del>\$0</del>	<del>All Costs</del>	<del>\$0</del>
21	<del>Next \$124 of Medicare</del>			
22	<del>Approved Amounts*</del>	<del>\$0</del>	<del>\$0</del>	<del>\$124</del>
23				<del>(Part B</del>
24				<del>Deductible)</del>
25	<del>Remainder of Medicare</del>			
26	<del>Approved Amounts</del>	<del>80%</del>	<del>20%</del>	<del>\$0</del>
27	<del>CLINICAL LABORATORY</del>			
28	<del>SERVICES—</del>			
29	<del>Tests for</del>			
30	<del>diagnostic services</del>	<del>100%</del>	<del>\$0</del>	<del>\$0</del>

1 ~~———— PARTS A & B~~

2	<del>HOME HEALTH CARE</del>			
3	<del>Medicare Approved</del>			
4	<del>Services</del>			
5	<del>Medically necessary</del>			
6	<del>skilled care services</del>			
7	<del>and medical supplies</del>	<del>100%</del>	<del>\$0</del>	<del>\$0</del>
8	<del>Durable medical</del>			
9	<del>equipment</del>			
10	<del>First \$124 of Medicare</del>			
11	<del>Approved Amounts*</del>	<del>\$0</del>	<del>\$0</del>	<del>\$124</del>
12				<del>(Part B</del>
13				<del>Deductible)</del>
14	<del>Remainder of Medicare</del>			
15	<del>Approved Amounts</del>	<del>80%</del>	<del>20%</del>	<del>\$0</del>

16 ~~———— OTHER BENEFITS NOT COVERED BY MEDICARE~~

17	<del>FOREIGN TRAVEL—</del>			
18	<del>Not covered by Medicare</del>			
19	<del>Medically necessary</del>			
20	<del>emergency care services</del>			
21	<del>beginning during the</del>			
22	<del>first 60 days of each</del>			
23	<del>trip outside the USA</del>			
24	<del>First \$250 each</del>			
25	<del>calendar year</del>	<del>\$0</del>	<del>\$0</del>	<del>\$250</del>

1	<del>Remainder of Charges</del>	<del>\$0</del>	<del>80% to a</del>	<del>20% and</del>
2			<del>lifetime</del>	<del>amounts</del>
3			<del>maximum</del>	<del>over the</del>
4			<del>benefit</del>	<del>\$50,000</del>
5			<del>of \$50,000</del>	<del>lifetime</del>
6				<del>maximum</del>
7	<del>PREVENTIVE MEDICAL CARE</del>			
8	<del>BENEFIT-</del>			
9	<del>Not covered by Medicare</del>			
10	<del>Annual physical and</del>			
11	<del>preventive tests and</del>			
12	<del>services</del>			
13				
14				
15				
16				
17				
18				
19				
20				
21				
22	<del>administered</del>			
23	<del>or ordered by your</del>			
24	<del>doctor when not covered</del>			
25	<del>by Medicare</del>			
26	<del>First \$120 each</del>			
27	<del>calendar year</del>	<del>\$0</del>	<del>\$120</del>	<del>\$0</del>
28	<del>Additional charges</del>	<del>\$0</del>	<del>\$0</del>	<del>All Costs</del>

29

PLAN F OR HIGH DEDUCTIBLE PLAN F

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

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

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

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

1		\$248 a day	a day	
2	91st day and after			
3	—While using 60			
4	lifetime reserve days	All but <del>\$476</del>	<del>\$476</del> \$496	\$0
5		\$496 a day	a day	
6	—Once lifetime reserve			
7	days are used:			
8	—Additional 365 days	\$0	100% of	\$0***
9			Medicare	
10			Eligible	
11			Expenses	
12	—Beyond the			
13	Additional 365 days	\$0	\$0	All Costs
14	SKILLED NURSING FACILITY			
15	CARE*			
16	You must meet Medicare's			
17	requirements, including			
18	having been in a			
19	hospital for at least			
20	3 days and entered a			
21	Medicare-approved			
22	facility within 30 days			
23	after leaving the			
24	hospital			
25	First 20 days	All approved		
26		amounts	\$0	\$0
27	21st thru 100th day	All but <del>\$119</del>	Up to <del>\$119</del>	\$0
28		\$124 a day	\$124 a day	
29	101st day and after	\$0	\$0	All costs
30	BLOOD			
31	First 3 pints	\$0	3 pints	\$0



1	Additional amounts	100%	\$0	\$0
2	HOSPICE CARE			
3	<del>Available as long as</del>	All but very	<del>\$0</del> <b>MEDICARE</b>	<del>Balance</del> <b>\$0</b>
4	<del>your doctor certifies</del>	limited	<b>COPAYMENT/</b>	
5	<del>you are terminally ill</del>	<b>COPAYMENT/</b>	<b>COINSURANCE</b>	
6	<del>and you elect to receive</del>	coinsurance		
7	<del>these services</del> <b>YOU MUST</b>	for		
8	<b>MEET MEDICARE'S</b>	outpatient		
9	<b>REQUIREMENTS, INCLUDING</b>	drugs and		
10	<b>A DOCTOR'S CERTIFICATION</b>	inpatient		
11	<b>OF TERMINAL ILLNESS</b>	respite care		

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

19 PLAN F

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

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

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

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

6	SERVICES	MEDICARE	AFTER YOU	IN ADDITION
7		PAYS	PAY <del>\$1,790</del>	TO <del>\$1,790</del>
8			<b>\$1,860</b>	<b>\$1,860</b>
9			DEDUCTIBLE**,	DEDUCTIBLE**,
10			PLAN PAYS	YOU PAY
11	MEDICAL EXPENSES—			
12	In or out of the hospital			
13	and outpatient hospital			
14	treatment, such as			
15	Physician's services,			
16	inpatient and outpatient			
17	medical and surgical			
18	services and supplies,			
19	physical and speech			
20	therapy, diagnostic			
21	tests, durable medical			
22	equipment,			
23	First <del>\$124</del> <b>\$131</b> of			
24	Medicare Approved	\$0	<del>\$124</del> <b>\$131</b>	\$0
25	Amounts*		(Part B	
26			Deductible)	
27	Remainder of Medicare			
28	Approved Amounts	80%	20%	\$0
29	Part B Excess Charges			
30	(Above Medicare			

1	Approved Amounts)	\$0	100%	\$0
2	BLOOD			
3	First 3 pints	\$0	All Costs	\$0
4	Next <del>\$124</del> \$131 of			
5	Medicare Approved	\$0	<del>\$124</del> \$131	\$0
6	Amounts*		(Part B	
7			Deductible)	
8	Remainder of Medicare			
9	Approved Amounts	80%	20%	\$0
10	CLINICAL LABORATORY			
11	SERVICES—			
12	Tests for			
13	diagnostic services	100%	\$0	\$0

14

## PARTS A &amp; B

15	HOME HEALTH CARE			
16	Medicare Approved			
17	Services			
18	—Medically necessary			
19	skilled care services			
20	and medical supplies	100%	\$0	\$0
21	—Durable medical			
22	equipment			
23	First <del>\$124</del> \$131 of			
24	Medicare Approved	\$0	<del>\$124</del> \$131	\$0
25	Amounts*		(Part B	
26			Deductible)	
27	Remainder of Medicare			

1	Approved Amounts	80%	20%	\$0
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2 OTHER BENEFITS—NOT COVERED BY MEDICARE

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

18 PLAN G

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

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

1	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
2	HOSPITALIZATION*			
3	Semiprivate room and			
4	board, general nursing			
5	and miscellaneous			
6	services and supplies			
7	First 60 days	All but <del>\$952</del>	<del>\$952</del> <b>\$992</b>	\$0
8		<b>\$992</b>	(Part A	
9			Deductible)	
10	61st thru 90th day	All but <del>\$238</del>	<del>\$238</del> <b>\$248</b>	\$0
11		<b>\$248</b> a day	a day	
12	91st day and after			
13	—While using 60			
14	lifetime reserve days	All but <del>\$476</del>	<del>\$476</del> <b>\$496</b>	\$0
15		<b>\$496</b> a day	a day	
16	—Once lifetime reserve			
17	days are used:			
18	—Additional 365 days	\$0	100% of	\$0**
19			Medicare	
20			Eligible	
21			Expenses	
22	—Beyond the			
23	Additional 365 days	\$0	\$0	All Costs
24	SKILLED NURSING FACILITY			
25	CARE*			
26	You must meet Medicare's			
27	requirements, including			
28	having been in a hospital			
29	for at least 3 days and			
30	entered a Medicare-			
31	approved facility within			

1	30 days after leaving the			
2	hospital			
3	First 20 days	All approved		
4		amounts	\$0	\$0
5	21st thru 100th day	All but <del>\$119</del>	Up to <del>\$119</del>	\$0
6		<b>\$124</b> a day	<b>\$124</b> a day	
7	101st day and after	\$0	\$0	All costs
8	BLOOD			
9	First 3 pints	\$0	3 pints	\$0
10	Additional amounts	100%	\$0	\$0
11	HOSPICE CARE			
12	<del>Available as long as your</del>	All but very	<del>\$0</del>	Balance <b>\$0</b>
13	<del>doctor certifies you are</del>	limited	<b>MEDICARE</b>	
14	<del>terminally ill and you</del>	<b>COPAYMENT/</b>	<b>COPAYMENT/</b>	
15	<del>elect to receive these</del>	coinsurance	<b>COINSURANCE</b>	
16	<del>services</del> <b>YOU MUST MEET</b>	for outpatient		
17	<b>MEDICARE'S REQUIREMENTS,</b>	drugs and		
18	<b>INCLUDING A DOCTOR'S</b>	inpatient		
19	<b>CERTIFICATION OF</b>	respite care		
20	<b>TERMINAL ILLNESS</b>			

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

28 PLAN G

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

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

5	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
6	MEDICAL EXPENSES—			
7	In or out of the hospital			
8	and outpatient hospital			
9	treatment, such as			
10	Physician's services,			
11	inpatient and outpatient			
12	medical and surgical			
13	services and supplies,			
14	physical and speech			
15	therapy, diagnostic			
16	tests, durable medical			
17	equipment,			
18	First <del>\$124</del> <b>\$131</b> of			
19	Medicare Approved	\$0	\$0	<del>\$124</del> <b>\$131</b>
20	Amounts*			(Part B
21				Deductible)
22	Remainder of Medicare			
23	Approved Amounts	80%	20%	\$0
24	Part B Excess Charges			
25	(Above Medicare			
26	Approved Amounts)	\$0	<del>80%</del> <b>100%</b>	<del>20%</del> <b>0%</b>
27	BLOOD			
28	First 3 pints	\$0	All Costs	\$0

1	Next <del>\$124</del> <b>\$131</b> of			
2	Medicare Approved	\$0	\$0	<del>\$124</del> <b>\$131</b>
3	Amounts*			(Part B
4				Deductible)
5	Remainder of Medicare			
6	Approved Amounts	80%	20%	\$0
7	CLINICAL LABORATORY			
8	SERVICES—			
9	Tests for			
10	diagnostic services	100%	\$0	\$0

11 PARTS A & B

12	HOME HEALTH CARE			
13	Medicare Approved			
14	Services			
15	—Medically necessary			
16	skilled care services			
17	and medical supplies	100%	\$0	\$0
18	—Durable medical			
19	equipment			
20	First <del>\$124</del> <b>\$131</b> of			
21	Medicare Approved	\$0	\$0	<del>\$124</del> <b>\$131</b>
22	Amounts*			(Part B
23				Deductible)
24	Remainder of Medicare			
25	Approved Amounts	80%	20%	\$0
26	<del>AT HOME RECOVERY</del>			
27	<del>SERVICES—</del>			
28	<del>Not covered by Medicare</del>			



1	<del>Home care certified by</del>			
2	<del>your doctor, for personal</del>			
3	<del>care during recovery from</del>			
4	<del>an injury or sickness for</del>			
5	<del>which Medicare approved a</del>			
6	<del>Home Care Treatment Plan</del>			
7	<del>Benefit for each visit</del>	<del>\$0</del>	<del>Actual</del>	
8			<del>Charges to</del>	
9			<del>\$40 a visit</del>	Balance
10	<del>Number of visits</del>			
11	<del>covered (must be</del>			
12	<del>received within 8</del>			
13	<del>weeks of last</del>			
14	<del>Medicare Approved</del>			
15	<del>visit)</del>	<del>\$0</del>	<del>Up to the</del>	
16			<del>number of</del>	
17			<del>Medicare</del>	
18			<del>Approved</del>	
19			<del>visits, not</del>	
20			<del>to exceed 7</del>	
21			<del>each week</del>	
22	<del>Calendar year maximum</del>	<del>\$0</del>	<del>\$1,600</del>	

23 OTHER BENEFITS—NOT COVERED BY MEDICARE

24	FOREIGN TRAVEL—			
25	Not covered by Medicare			
26	Medically necessary			
27	emergency care services			
28	beginning during the			

1	first 60 days of each			
2	trip outside the USA			
3	First \$250 each			
4	calendar year	\$0	\$0	\$250
5	Remainder of charges	\$0	80% to a	20% and
6			lifetime	amounts
7			maximum	over the
8			benefit	\$50,000
9			of \$50,000	lifetime
10				maximum

11 ~~PLAN H~~

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

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

17	<del>SERVICES</del>	<del>MEDICARE PAYS</del>	<del>PLAN PAYS</del>	<del>YOU PAY</del>
18	<del>HOSPITALIZATION*</del>			
19	<del>Semiprivate room and</del>			
20	<del>board, general nursing</del>			
21	<del>and miscellaneous</del>			
22	<del>services and supplies</del>			
23	<del>First 60 days</del>	<del>All but \$952</del>	<del>\$952</del>	<del>\$0</del>
24			<del>(Part A</del>	
25			<del>Deductible)</del>	
26	<del>61st thru 90th day</del>	<del>All but \$238</del>	<del>\$238</del>	<del>\$0</del>

1		a day	a day	
2	<del>91st day and after</del>			
3	<del>While using 60</del>			
4	<del>lifetime reserve days</del>	<del>All but \$476</del>	<del>\$476</del>	<del>\$0</del>
5		a day	a day	
6	<del>Once lifetime reserve</del>			
7	<del>days are used:</del>			
8	<del>Additional 365 days</del>	<del>\$0</del>	<del>100% of</del>	<del>\$0</del>
9			Medicare	
10			Eligible	
11			Expenses	
12	<del>Beyond the</del>			
13	<del>Additional 365 days</del>	<del>\$0</del>	<del>\$0</del>	<del>All Costs</del>
14	<del>SKILLED NURSING FACILITY</del>			
15	<del>CARE*</del>			
16	<del>You must meet Medicare's</del>			
17	<del>requirements, including</del>			
18	<del>having been in a hospital</del>			
19	<del>for at least 3 days and</del>			
20	<del>entered a Medicare-</del>			
21	<del>approved facility within</del>			
22	<del>30 days after leaving the</del>			
23	<del>hospital</del>			
24	<del>First 20 days</del>	<del>All approved</del>		
25		<del>amounts</del>	<del>\$0</del>	<del>\$0</del>
26	<del>21st thru 100th day</del>	<del>All but \$119</del>	<del>Up to \$119</del>	<del>\$0</del>
27		a day	a day	
28	<del>101st day and after</del>	<del>\$0</del>	<del>\$0</del>	<del>All costs</del>
29	<del>BLOOD</del>			
30	<del>First 3 pints</del>	<del>\$0</del>	<del>3 pints</del>	<del>\$0</del>
31	<del>Additional amounts</del>	<del>100%</del>	<del>\$0</del>	<del>\$0</del>

1	<del>HOSPICE CARE</del>			
2	<del>Available as long as your</del>	<del>All but very</del>	<del>\$0</del>	<del>Balance</del>
3	<del>doctor certifies you are</del>	<del>limited</del>		
4	<del>terminally ill and you</del>	<del>coinsurance</del>		
5	<del>elect to receive these</del>	<del>for outpatient</del>		
6	<del>services</del>	<del>drugs and</del>		
7		<del>inpatient</del>		
8		<del>respite care</del>		

9 ~~\_\_\_\_\_ PLAN H~~

10 ~~\_\_\_\_\_ MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR~~

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

14	<del>_____ SERVICES</del>	<del>_____ MEDICARE PAYS</del>	<del>_____ PLAN PAYS</del>	<del>_____ YOU PAY</del>
15	<del>MEDICAL EXPENSES—</del>			
16	<del>In or out of the hospital</del>			
17	<del>and outpatient hospital</del>			
18	<del>treatment, such as</del>			
19	<del>Physician's services,</del>			
20	<del>inpatient and outpatient</del>			
21	<del>medical and surgical</del>			
22	<del>services and supplies,</del>			
23	<del>physical and speech</del>			
24	<del>therapy, diagnostic</del>			
25	<del>tests, durable medical</del>			
26	<del>equipment,</del>			
27	<del>First \$124 of Medicare</del>			

1	<del>Approved Amounts*</del>	<del>\$0</del>	<del>\$0</del>	<del>\$124</del>
2				<del>(Part B</del>
3				<del>Deductible)</del>
4	<del>Remainder of Medicare</del>			
5	<del>Approved Amounts</del>	<del>80%</del>	<del>20%</del>	<del>\$0</del>
6	<del>Part B Excess Charges</del>			
7	<del>(Above Medicare</del>			
8	<del>Approved Amounts)</del>	<del>\$0</del>	<del>\$0</del>	<del>All Costs</del>
9	<del>BLOOD</del>			
10	<del>First 3 pints</del>	<del>\$0</del>	<del>All Costs</del>	<del>\$0</del>
11	<del>Next \$124 of Medicare</del>			
12	<del>Approved Amounts*</del>	<del>\$0</del>	<del>\$0</del>	<del>\$124</del>
13				<del>(Part B</del>
14				<del>Deductible)</del>
15	<del>Remainder of Medicare</del>			
16	<del>Approved Amounts</del>	<del>80%</del>	<del>20%</del>	<del>\$0</del>
17	<del>CLINICAL LABORATORY</del>			
18	<del>SERVICES</del>			
19	<del>Tests for</del>			
20	<del>diagnostic services</del>	<del>100%</del>	<del>\$0</del>	<del>\$0</del>

21 ~~\_\_\_\_\_ PARTS A & B~~

22	<del>HOME HEALTH CARE</del>			
23	<del>Medicare Approved</del>			
24	<del>Services</del>			
25	<del>Medically necessary</del>			
26	<del>skilled care services</del>			
27	<del>and medical supplies</del>	<del>100%</del>	<del>\$0</del>	<del>\$0</del>

1	<del>Durable medical</del>			
2	<del>equipment</del>			
3	<del>First \$124 of Medicare</del>			
4	<del>Approved Amounts*</del>	<del>\$0</del>	<del>\$0</del>	<del>\$124</del>
5				<del>(Part B</del>
6				<del>Deductible)</del>
7	<del>Remainder of Medicare</del>			
8	<del>Approved Amounts</del>	<del>80%</del>	<del>20%</del>	<del>\$0</del>

9 ~~OTHER BENEFITS NOT COVERED BY MEDICARE~~

10	<del>FOREIGN TRAVEL</del>			
11	<del>Not covered by Medicare</del>			
12	<del>Medically necessary</del>			
13	<del>emergency care services</del>			
14	<del>beginning during the</del>			
15	<del>first 60 days of each</del>			
16	<del>trip outside the USA</del>			
17	<del>First \$250 each</del>			
18	<del>calendar year</del>	<del>\$0</del>	<del>\$0</del>	<del>\$250</del>
19	<del>Remainder of Charges</del>	<del>\$0</del>	<del>80% to a</del>	<del>20% and</del>
20			<del>lifetime</del>	<del>amounts</del>
21			<del>maximum</del>	<del>over the</del>
22			<del>benefit</del>	<del>\$50,000</del>
23			<del>of \$50,000</del>	<del>lifetime</del>
24				<del>maximum</del>
25				
26				
27				
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10 ~~PLAN I~~

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

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

16	<del>SERVICES</del>	<del>MEDICARE PAYS</del>	<del>PLAN PAYS</del>	<del>YOU PAY</del>
17	<del>HOSPITALIZATION*</del>			
18	<del>Semiprivate room and</del>			
19	<del>board, general nursing</del>			
20	<del>and miscellaneous</del>			
21	<del>services and supplies</del>			
22	<del>First 60 days</del>	<del>All but \$952</del>	<del>\$952</del>	<del>\$0</del>
23			<del>(Part A</del>	
24			<del>Deductible)</del>	
25	<del>61st thru 90th day</del>	<del>All but \$238</del>	<del>\$238</del>	<del>\$0</del>
26		<del>a day</del>	<del>a day</del>	

1	<del>91st day and after</del>			
2	<del>While using 60</del>			
3	<del>lifetime reserve days</del>	<del>All but \$476</del>	<del>\$476</del>	<del>\$0</del>
4		<del>a day</del>	<del>a day</del>	
5	<del>Once lifetime reserve</del>			
6	<del>days are used:</del>			
7	<del>Additional 365 days</del>	<del>\$0</del>	<del>100% of</del>	<del>\$0</del>
8			<del>Medicare</del>	
9			<del>Eligible</del>	
10			<del>Expenses</del>	
11	<del>Beyond the</del>			
12	<del>Additional 365 days</del>	<del>\$0</del>	<del>\$0</del>	<del>All Costs</del>
13	<del>SKILLED NURSING FACILITY</del>			
14	<del>CARE*</del>			
15	<del>You must meet Medicare's</del>			
16	<del>requirements, including</del>			
17	<del>having been in a hospital</del>			
18	<del>for at least 3 days and</del>			
19	<del>entered a Medicare-</del>			
20	<del>approved facility within</del>			
21	<del>30 days after leaving the</del>			
22	<del>hospital</del>			
23	<del>First 20 days</del>	<del>All approved</del>		
24		<del>amounts</del>	<del>\$0</del>	<del>\$0</del>
25	<del>21st thru 100th day</del>	<del>All but \$119</del>	<del>Up to \$119</del>	<del>\$0</del>
26		<del>a day</del>	<del>a day</del>	
27	<del>101st day and after</del>	<del>\$0</del>	<del>\$0</del>	<del>All costs</del>
28	<del>BLOOD</del>			
29	<del>First 3 pints</del>	<del>\$0</del>	<del>3 pints</del>	<del>\$0</del>
30	<del>Additional amounts</del>	<del>100%</del>	<del>\$0</del>	<del>\$0</del>
31	<del>HOSPICE CARE</del>			



1	<del>Available as long as your</del>	<del>All but very</del>	<del>\$0</del>	<del>Balance</del>
2	<del>doctor certifies you are</del>	<del>limited</del>		
3	<del>terminally ill and you</del>	<del>coinsurance</del>		
4	<del>elect to receive these</del>	<del>for outpatient</del>		
5	<del>services</del>	<del>drugs and</del>		
6		<del>inpatient</del>		
7		<del>respite care</del>		

8 ~~PLAN I~~

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

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

13	<del>SERVICES</del>	<del>MEDICARE PAYS</del>	<del>PLAN PAYS</del>	<del>YOU PAY</del>
14	<del>MEDICAL EXPENSES—</del>			
15	<del>In or out of the hospital</del>			
16	<del>and outpatient hospital</del>			
17	<del>treatment, such as</del>			
18	<del>Physician's services,</del>			
19	<del>inpatient and outpatient</del>			
20	<del>medical and surgical</del>			
21	<del>services and supplies,</del>			
22	<del>physical and speech</del>			
23	<del>therapy, diagnostic</del>			
24	<del>tests, durable medical</del>			
25	<del>equipment,</del>			
26	<del>First \$124 of Medicare</del>			
27	<del>Approved Amounts*</del>	<del>\$0</del>	<del>\$0</del>	<del>\$124</del>

1				(Part B
2				Deductible)
3	<del>Remainder of Medicare</del>			
4	<del>Approved Amounts</del>	<del>80%</del>	<del>20%</del>	<del>\$0</del>
5	<del>Part B Excess Charges</del>			
6	<del>(Above Medicare</del>			
7	<del>Approved Amounts)</del>	<del>\$0</del>	<del>100%</del>	<del>\$0</del>
8	<del>BLOOD</del>			
9	<del>First 3 pints</del>	<del>\$0</del>	<del>All Costs</del>	<del>\$0</del>
10	<del>Next \$124 of Medicare</del>			
11	<del>Approved Amounts*</del>	<del>\$0</del>	<del>\$0</del>	<del>\$124</del>
12				(Part B
13				Deductible)
14	<del>Remainder of Medicare</del>			
15	<del>Approved Amounts</del>	<del>80%</del>	<del>20%</del>	<del>\$0</del>
16	<del>CLINICAL LABORATORY</del>			
17	<del>SERVICES—</del>			
18	<del>Tests for</del>			
19	<del>diagnostic services</del>	<del>100%</del>	<del>\$0</del>	<del>\$0</del>

20 ~~PARTS A & B~~

21	<del>HOME HEALTH CARE</del>			
22	<del>Medicare Approved</del>			
23	<del>Services</del>			
24	<del>Medically necessary</del>			
25	<del>skilled care services</del>			
26	<del>and medical supplies</del>	<del>100%</del>	<del>\$0</del>	<del>\$0</del>
27	<del>Durable medical</del>			

1	<del>equipment</del>			
2	<del>First \$124 of Medicare</del>			
3	<del>Approved Amounts*</del>	<del>\$0</del>	<del>\$0</del>	<del>\$124</del>
4				<del>(Part B</del>
5				<del>Deductible)</del>
6	<del>Remainder of Medicare</del>			
7	<del>Approved Amounts</del>	<del>80%</del>	<del>20%</del>	<del>\$0</del>
8	<del>AT HOME RECOVERY</del>			
9	<del>SERVICES—</del>			
10	<del>Not covered by Medicare</del>			
11	<del>Home care certified by</del>			
12	<del>your doctor, for personal</del>			
13	<del>care during recovery from</del>			
14	<del>an injury or sickness for</del>			
15	<del>which Medicare approved a</del>			
16	<del>Home Care Treatment Plan</del>			
17	<del>Benefit for each visit</del>	<del>\$0</del>	<del>Actual</del>	
18			<del>Charges to</del>	
19			<del>\$40 a visit</del>	<del>Balance</del>
20	<del>Number of visits</del>			
21	<del>covered (must be</del>			
22	<del>received within 8</del>			
23	<del>weeks of last</del>			
24	<del>Medicare Approved</del>			
25	<del>visit)</del>	<del>\$0</del>	<del>Up to the</del>	
26			<del>number of</del>	
27			<del>Medicare</del>	
28			<del>Approved</del>	
29			<del>visits, not</del>	
30			<del>to exceed 7</del>	
31			<del>each week</del>	

1	<del>Calendar year maximum</del>	<del>\$0</del>	<del>\$1,600</del>	
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2 ~~OTHER BENEFITS NOT COVERED BY MEDICARE~~

3	<del>FOREIGN TRAVEL</del>			
4	<del>Not covered by Medicare</del>			
5	<del>Medically necessary</del>			
6	<del>emergency care services</del>			
7	<del>beginning during the</del>			
8	<del>first 60 days of each</del>			
9	<del>trip outside the USA</del>			
10	<del>First \$250 each</del>			
11	<del>calendar year</del>	<del>\$0</del>	<del>\$0</del>	<del>\$250</del>
12	<del>Remainder of Charges*</del>	<del>\$0</del>	<del>80% to a</del>	<del>20% and</del>
13			<del>lifetime</del>	<del>amounts</del>
14			<del>maximum</del>	<del>over the</del>
15			<del>benefit</del>	<del>\$50,000</del>
16			<del>of \$50,000</del>	<del>lifetime</del>
17				<del>maximum</del>
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23 ~~PLAN J OR HIGH DEDUCTIBLE PLAN J~~4 ~~MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD~~

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

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

17	<del>SERVICES</del>	<del>MEDICARE PAYS</del>	<del>AFTER YOU</del>	<del>IN ADDITION</del>
18			<del>PAY \$1,790</del>	<del>TO \$1,790</del>
19			<del>DEDUCTIBLE**,</del>	<del>DEDUCTIBLE**,</del>
20			<del>PLAN PAYS</del>	<del>YOU PAY</del>
21	<del>HOSPITALIZATION*</del>			
22	<del>Semiprivate room and</del>			
23	<del>board, general nursing</del>			
24	<del>and miscellaneous</del>			

1	<del>services and supplies</del>			
2	<del>First 60 days</del>	<del>All but \$952</del>	<del>\$952</del>	<del>\$0</del>
3			<del>(Part A</del>	
4			<del>Deductible)</del>	
5	<del>61st thru 90th day</del>	<del>All but \$238</del>	<del>\$238</del>	<del>\$0</del>
6		<del>a day</del>	<del>a day</del>	
7	<del>91st day and after</del>			
8	<del>While using 60</del>			
9	<del>lifetime reserve days</del>	<del>All but \$476</del>	<del>\$476</del>	<del>\$0</del>
10		<del>a day</del>	<del>a day</del>	
11	<del>Once lifetime reserve</del>			
12	<del>days are used:</del>			
13	<del>Additional 365 days</del>	<del>\$0</del>	<del>100% of</del>	<del>\$0***</del>
14			<del>Medicare</del>	
15			<del>Eligible</del>	
16			<del>Expenses</del>	
17	<del>Beyond the</del>			
18	<del>Additional 365 days</del>	<del>\$0</del>	<del>\$0</del>	<del>All Costs</del>
19	<del>SKILLED NURSING FACILITY</del>			
20	<del>CARE*</del>			
21	<del>You must meet Medicare's</del>			
22	<del>requirements, including</del>			
23	<del>having been in a hospital</del>			
24	<del>for at least 3 days and</del>			
25	<del>entered a Medicare-</del>			
26	<del>approved facility within</del>			
27	<del>30 days after leaving the</del>			
28	<del>hospital</del>			
29	<del>First 20 days</del>	<del>All approved</del>		
30		<del>amounts</del>	<del>\$0</del>	<del>\$0</del>
31	<del>21st thru 100th day</del>	<del>All but \$119</del>	<del>Up to \$119</del>	<del>\$0</del>

1		a day	a day	
2	<del>101st day and after</del>	<del>\$0</del>	<del>\$0</del>	<del>All costs</del>
3	<del>BLOOD</del>			
4	<del>First 3 pints</del>	<del>\$0</del>	<del>3 pints</del>	<del>\$0</del>
5	<del>Additional amounts</del>	<del>100%</del>	<del>\$0</del>	<del>\$0</del>

~~6       \*\*\*NOTICE: When your Medicare Part A hospital benefits are~~  
~~7       exhausted, the insurer stands in the place of Medicare and will~~  
~~8       pay whatever amount medicare would have paid for up to an~~  
~~9       additinal 365 days as provided in the policy's "core benefits."~~  
~~10      During this time the hospital is prohibited from billing you for~~  
~~11      the balance based on any difference between its billed charges~~  
~~12      and the amount medicare would have paid.~~

13       \_\_\_\_\_ PLAN J

14       \_\_\_\_\_ MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

~~15      \*Once you have been billed \$124 of Medicare Approved amounts~~  
~~16      for covered services (which are noted with an asterisk), your~~  
~~17      Part B Deductible will have been met for the calendar year.~~

~~18      \*\*This high deductible plan pays the same benefits as plan J~~  
~~19      after you have paid a calendar year (\$1,790) deductible.~~  
~~20      Benefits from the high deductible plan J will not begin until~~  
~~21      out of pocket expenses are \$1,790. Out of pocket expenses for~~  
~~22      this deductible are expenses that would ordinarily be paid by the~~  
~~23      policy. This includes medicare deductibles for part A and part B,~~  
~~24      but does not include the plan's separate outpatient prescription~~  
~~25      drug deductible or foreign travel emergency deductible.~~

1	<del>SERVICES</del>	<del>MEDICARE PAYS</del>	<del>AFTER YOU</del>	<del>IN ADDITION</del>
2			<del>PAY \$1,790</del>	<del>TO \$1,790</del>
3			<del>DEDUCTIBLE**,</del>	<del>DEDUCTIBLE**</del>
4			<del>PLAN PAYS</del>	<del>YOU PAY</del>
5	<del>HOSPICE CARE</del>			
6	<del>Available as long as your</del>	<del>All but very</del>	<del>\$0</del>	<del>Balance</del>
7	<del>doctor certifies you are</del>	<del>limited</del>		
8	<del>terminally ill and you</del>	<del>coinsurance</del>		
9	<del>elect to receive these</del>	<del>for outpatient</del>		
10	<del>services</del>	<del>drugs and</del>		
11		<del>inpatient</del>		
12		<del>respite care</del>		
13	<del>MEDICAL EXPENSES—</del>			
14	<del>In or out of the hospital</del>			
15	<del>and outpatient hospital</del>			
16	<del>treatment, such as</del>			
17	<del>Physician's services,</del>			
18	<del>inpatient and outpatient</del>			
19	<del>medical and surgical</del>			
20	<del>services and supplies,</del>			
21	<del>physical and speech</del>			
22	<del>therapy, diagnostic</del>			
23	<del>tests, durable medical</del>			
24	<del>equipment,</del>			
25	<del>First \$124 of Medicare</del>			
26	<del>Approved Amounts*</del>	<del>\$0</del>	<del>\$124</del>	<del>\$0</del>
27			<del>(Part B</del>	
28			<del>Deductible)</del>	



1	<del>Remainder of Medicare</del>			
2	<del>Approved Amounts</del>	<del>80%</del>	<del>20%</del>	<del>\$0</del>
3	<del>Part B Excess Charges</del>			
4	<del>(Above Medicare</del>			
5	<del>Approved Amounts)</del>	<del>\$0</del>	<del>100%</del>	<del>\$0</del>
6	<del>BLOOD</del>			
7	<del>First 3 pints</del>	<del>\$0</del>	<del>All Costs</del>	<del>\$0</del>
8	<del>Next \$124 of Medicare</del>			
9	<del>Approved Amounts*</del>	<del>\$0</del>	<del>\$124</del>	<del>\$0</del>
10			<del>(Part B</del>	
11			<del>Deductible)</del>	
12	<del>Remainder of Medicare</del>			
13	<del>Approved Amounts</del>	<del>80%</del>	<del>20%</del>	<del>\$0</del>
14	<del>CLINICAL LABORATORY</del>			
15	<del>SERVICES—</del>			
16	<del>Tests for</del>			
17	<del>diagnostic services</del>	<del>100%</del>	<del>\$0</del>	<del>\$0</del>

18 ~~———— PARTS A & B~~

19	<del>HOME HEALTH CARE</del>			
20	<del>Medicare Approved</del>			
21	<del>Services</del>			
22	<del>Medically necessary</del>			
23	<del>skilled care services</del>			
24	<del>and medical supplies</del>	<del>100%</del>	<del>\$0</del>	<del>\$0</del>
25	<del>Durable medical</del>			
26	<del>equipment</del>			
27	<del>First \$124 of Medicare</del>			

1	<del>Approved Amounts*</del>	<del>\$0</del>	<del>\$124</del>	<del>\$0</del>
2			<del>(Part B</del>	
3			<del>Deductible)</del>	
4	<del>Remainder of Medicare</del>			
5	<del>Approved Amounts</del>	<del>80%</del>	<del>20%</del>	<del>\$0</del>
6	<del>AT HOME RECOVERY</del>			
7	<del>SERVICES—</del>			
8	<del>Not covered by Medicare</del>			
9	<del>Home care certified by</del>			
10	<del>your doctor, for personal</del>			
11	<del>care beginning during</del>			
12	<del>recovery from an injury</del>			
13	<del>or sickness for which</del>			
14	<del>Medicare approved a</del>			
15	<del>Home Care Treatment Plan</del>			
16	<del>Benefit for each visit</del>	<del>\$0</del>	<del>Actual</del>	
17			<del>Charges to</del>	
18			<del>\$40 a visit</del>	<del>Balance</del>
19	<del>Number of visits</del>			
20	<del>covered (must be</del>			
21	<del>received within 8</del>			
22	<del>weeks of last</del>			
23	<del>Medicare Approved</del>			
24	<del>visit)</del>	<del>\$0</del>	<del>Up to the</del>	
25			<del>number of</del>	
26			<del>Medicare</del>	
27			<del>Approved</del>	
28			<del>visits, not</del>	
29			<del>to exceed 7</del>	
30	<del>Calendar year maximum</del>	<del>\$0</del>	<del>\$1,600</del>	

1 ~~OTHER BENEFITS NOT COVERED BY MEDICARE~~

2 <del>FOREIGN TRAVEL-</del>			
3 <del>Not covered by Medicare</del>			
4 <del>Medically necessary</del>			
5 <del>emergency care services</del>			
6 <del>beginning during the</del>			
7 <del>first 60 days of each</del>			
8 <del>trip outside the USA</del>			
9 <del>First \$250 each</del>			
10 <del>calendar year</del>	<del>\$0</del>	<del>\$0</del>	<del>\$250</del>
11 <del>Remainder of Charges</del>	<del>\$0</del>	<del>80% to a</del>	<del>20% and</del>
12		<del>lifetime</del>	<del>amounts</del>
13		<del>maximum</del>	<del>over the</del>
14		<del>benefit</del>	<del>\$50,000</del>
15		<del>of \$50,000</del>	<del>lifetime</del>
16			<del>maximum</del>
17 <del>PREVENTIVE MEDICAL CARE</del>			
18 <del>BENEFIT-</del>			
19 <del>Not covered by Medicare</del>			
20 <del>Annual physical and</del>			
21 <del>preventive tests and</del>			
22 <del>services</del>			
23 <del>administered</del>			
24 <del>or ordered by your doctor</del>			
25 <del>when not covered by</del>			
26 <del>Medicare</del>			
27 <del>First \$120 each</del>			
28 <del>calendar year</del>	<del>\$0</del>	<del>\$120</del>	<del>\$0</del>

1	<del>Additional charges</del>	<del>\$0</del>	<del>\$0</del>	<del>All costs</del>
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2 PLAN K

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

14 PLAN K

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

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

20	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
21	HOSPITALIZATION**			
22	Semiprivate room and			
23	board, general nursing			

1	and miscellaneous			
2	services and supplies			
3	First 60 days	All but <del>\$952</del>	<del>\$476</del> <b>\$496</b>	<del>\$476</del> <b>\$496</b>
4		<b>\$992</b>	(50%	(50% of
5			of Part A	Part A
6			Deducti-	Deductible)
7			ble)	1
8				
9	61st thru 90th day	All but <del>\$238</del>	<del>\$238</del> <b>\$248</b>	\$0
10		<b>\$248</b> a day	a day	
11	91st day and after:			
12	—While using 60			
13	lifetime reserve days	All but <del>\$476</del>	<del>\$476</del> <b>\$496</b>	\$0
14		<b>\$496</b> a day	a day	
15	—Once lifetime reserve			
16	days are used:			
17	—Additional 365 days	\$0	100% of	\$0***
18			Medicare	
19			Eligible	
20			Expenses	
21	—Beyond the			
22	Additional 365 days	\$0	\$0	All Costs
23	SKILLED NURSING FACILITY			
24	CARE**			
25	You must meet Medicare's			
26	requirements, including			
27	having been in a hospital			
28	for at least 3 days and			
29	entered a Medicare-			
30	approved facility within			
31	30 days after leaving the			

1	hospital			
2	First 20 days	All approved		
3		amounts	\$0	\$0
4	21st thru 100th day	All but	Up to	Up to
5		<del>\$119</del> \$124 a	<del>\$59.50</del> \$62	<del>\$59.50</del> \$62
6		day	a day	a day 1
7	101st day and after	\$0	\$0	All costs
8	BLOOD			
9	First 3 pints	\$0	50%	50% 1
10	Additional amounts	100%	\$0	\$0
11	HOSPICE CARE			
12	<del>Available as long as your</del>	<del>Generally,</del>	50% of	50% of
13	<del>doctor certifies you are</del>	<del>most Medicare</del>	<b>COPAYMENT/</b>	<b>MEDICARE</b>
14	<del>terminally ill and you</del>	<del>eligible</del>	coinsur-	<b>COPAYMENT/</b>
15	<del>elect to receive these</del>	<del>expenses for</del>	ance or	coinsurance
16	<del>services</del> <b>YOU MUST MEET</b>	<del>outpatient</del>	<del>copayments</del>	<del>or copay-</del>
17	<b>MEDICARE'S REQUIREMENTS,</b>	<del>drugs and</del>		<del>ments 1</del>
18	<b>INCLUDING A DOCTOR'S</b>	<del>inpatient</del>		
19	<b>CERTIFICATION OF TERMINAL</b>	<del>respite care</del>		
20	<b>ILLNESS</b>	<b>ALL BUT VERY</b>		
21		<b>LIMITED</b>		
22		<b>COPAYMENT/</b>		
23		<b>COINSURANCE FOR</b>		
24		<b>OUTPATIENT</b>		
25		<b>DRUGS AND</b>		
26		<b>INPATIENT</b>		
27		<b>RESPITE CARE</b>		

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

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

5

## PLAN K

6

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

7

\*\*\*\*Once you have been billed ~~\$124~~**\$131** of Medicare-Approved

8

amounts for covered services (which are noted with an asterisk),

9

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

10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
11	MEDICAL EXPENSES—			
12	In or out of the hospital			
13	and outpatient hospital			
14	treatment, such as			
15	Physician's services,			
16	inpatient and outpatient			
17	medical and surgical			
18	services and supplies,			
19	physical and speech			
20	therapy, diagnostic			
21	tests, durable medical			
22	equipment,			
23	First <del>\$124</del> <b>\$131</b> of			
24	Medicare Approved	\$0	\$0	<del>\$124</del> <b>\$131</b>
25	Amounts****			(Part B
26				Deductible)

1				**** 1
2				
3	Preventive Benefits for	Generally 75%	Remainder	All costs
4	Medicare covered	or more of	of Medi-	above Medi-
5	services	Medicare ap-	care	care
6		proved amounts	approved	approved
7			amounts	amounts
8	Remainder of Medicare	Generally 80%	Generally	Generally
9	Approved Amounts		10%	10% 1
10				
11	Part B Excess Charges	\$0	\$0	All costs
12	(Above Medicare			(and they do
13	Approved Amounts)			not count
14				toward
15				annual out-
16				of-pocket
17				limit of
18				<del>\$4,000</del> \$4,140) *
19	BLOOD			
20	First 3 pints	\$0	50%	50% 1
21	Next <del>\$124</del> \$131 of			
22	Medicare Approved	\$0	\$0	<del>\$124</del> \$131
23	Amounts****			(Part B
24				Deductible)
25				**** 1
26	Remainder of Medicare	Generally 80%	Generally	Generally
27	Approved Amounts		10%	10% 1
28	CLINICAL LABORATORY			
29	SERVICES—Tests for			
30	diagnostic services	100%	\$0	\$0



## 8

9	HOME HEALTH CARE			
10	Medicare Approved			
11	Services			
12	—Medically necessary			
13	skilled care services			
14	and medical supplies	100%	\$0	\$0
15	—Durable medical			
16	equipment			
17	First <del>\$124</del> <b>\$131</b> of			
18	Medicare Approved	\$0	\$0	<del>\$124</del> <b>\$131</b>
19	Amounts*****			(Part B
20				Deductible)1
21	Remainder of Medicare			
22	Approved Amounts	80%	10%	10% 1

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

## 25

1           \*You will pay one-fourth of the cost-sharing of some covered  
2 services until you reach the annual out-of-pocket limit of  
3 ~~\$2,000~~**\$2,070** each calendar year. The amounts that count toward  
4 your annual limit are noted with diamonds -->superscript<--1 in  
5 the chart below. Once you reach the annual limit, the plan pays  
6 100% of your Medicare copayment and coinsurance for the rest of  
7 the calendar year. However, this limit does NOT include charges  
8 from your provider that exceed Medicare-approved amounts (these  
9 are called "Excess Charges") and you will be responsible for  
10 paying this difference in the amount charged by your provider and  
11 the amount paid by Medicare for the item or service.

## PLAN L

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

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

18	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
19	HOSPITALIZATION**			
20	Semiprivate room and			
21	board, general nursing			
22	and miscellaneous			
23	services and supplies			
24	First 60 days	All but \$952	\$714 <b>\$744</b>	<del>\$238</del> <b>\$248</b>
25		<b>\$992</b>	(75% of	(25% of

1			Part A	Part A
2			Deducti-	Deductible)
3			ble)	1
4	61st thru 90th day	All but <del>\$238</del>	<del>\$238</del> <b>\$248</b>	\$0
5		<b>\$248</b> a day	a day	
6	91st day and after:			
7	—While using 60			
8	lifetime reserve days	All but <del>\$476</del>	<del>\$476</del> <b>\$496</b>	\$0
9		<b>\$496</b> a day	a day	
10	—Once lifetime reserve			
11	days are used:			
12	—Additional 365 days	\$0	100% of	\$0***
13			Medicare	
14			Eligible	
15			Expenses	
16	—Beyond the			
17	Additional 365 days	\$0	\$0	All Costs
18	SKILLED NURSING FACILITY			
19	CARE**			
20	You must meet Medicare's			
21	requirements, including			
22	having been in a hospital			
23	for at least 3 days and			
24	entered a Medicare-			
25	approved facility within			
26	30 days after leaving the			
27	hospital			
28	First 20 days	All approved		
29		amounts	\$0	\$0
30	21st thru 100th day	All but	Up to	Up to
31		<del>\$119</del> <b>\$124</b> a	<del>\$89.25</del> <b>\$93</b>	<del>\$29.75</del> <b>\$31</b>

1		day	a day	a day 1
2	101st day and after	\$0	\$0	All costs
3	BLOOD			
4	First 3 pints	\$0	75%	25% 1
5	Additional amounts	100%	\$0	\$0
6	HOSPICE CARE			
7	<del>Available as long as your</del>	<del>Generally,</del>	75% of	25% of
8	<del>doctor certifies you are</del>	<del>most Medicare</del>	<b>COPAYMENT/</b>	<b>COPAYMENT/</b>
9	<del>terminally ill and you</del>	<del>eligible</del>	coinsur-	coinsurance
10	<del>elect to receive these</del>	<del>expenses for</del>	ance or	or copay-
11	<del>services</del> <b>YOU MUST MEET</b>	<del>outpatient</del>	<del>copayments</del>	<del>ments 1</del>
12	<b>MEDICARE'S REQUIREMENTS,</b>	<del>drugs and</del>		
13	<b>INCLUDING A DOCTOR'S</b>	<del>inpatient</del>		
14	<b>CERTIFICATION OF TERMINAL</b>	<del>respite care</del> <b>ALL</b>		
15	<b>ILLNESS</b>	<b>BUT VERY</b>		
16		<b>LIMITED COPAY-</b>		
17		<b>MENT/COINSUR-</b>		
18		<b>ANCE FOR</b>		
19		<b>OUTPATIENT</b>		
20		<b>DRUGS AND</b>		
21		<b>INPATIENT</b>		
22		<b>RESPITE CARE</b>		

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

## PLAN L

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

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

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

1	Remainder of Medicare	Generally	Generally	Generally
2	Approved Amounts	80%	15%	5% 1
3				
4	Part B Excess Charges	\$0	\$0	All costs
5	(Above Medicare			(and they do
6	Approved Amounts)			not count
7				toward
8				annual out-
9				of-pocket
10				limit of
11				<del>\$2,000</del> \$2,070) *
12	BLOOD			
13	First 3 pints	\$0	75%	25% 1
14	Next <del>\$124</del> \$131 of			
15	Medicare Approved	\$0	\$0	<del>\$124</del> \$131
16	Amounts****			(Part B
17				Deductible) 1
18	Remainder of Medicare	Generally	Generally	Generally
19	Approved Amounts	80%	15%	5% 1
20	CLINICAL LABORATORY			
21	SERVICES—Tests for			
22	diagnostic services	100%	\$0	\$0

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

1

## PARTS A &amp; B

2	HOME HEALTH CARE			
3	Medicare Approved			
4	Services			
5	—Medically necessary			
6	skilled care services			
7	and medical supplies	100%	\$0	\$0
8	—Durable medical			
9	equipment			
10	First <del>\$124</del> \$131 of			
11	Medicare Approved	\$0	\$0	<del>\$124</del> \$131
12	Amounts*****			(Part
13				B Deducti-
14				ble) 1
15	Remainder of Medicare			
16	Approved Amounts	80%	15%	5% 1

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

19

## PLAN M

20

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

21

\*A BENEFIT PERIOD BEGINS ON THE FIRST DAY YOU RECEIVE

22

SERVICE AS AN INPATIENT IN A HOSPITAL AND ENDS AFTER YOU HAVE

23

BEEN OUT OF THE HOSPITAL AND HAVE NOT RECEIVED SKILLED CARE IN

24

ANY OTHER FACILITY FOR 60 DAYS IN A ROW.

1	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
2	HOSPITALIZATION*			
3	SEMIPRIVATE ROOM AND			
4	BOARD, GENERAL NURSING			
5	AND MISCELLANEOUS			
6	SERVICES AND SUPPLIES			
7	FIRST 60 DAYS	ALL BUT \$992	\$496 (50%	\$496 (50%
8			OF PART A	OF PART A
9			DEDUC-	DEDUC-
10			TIBLE)	TIBLE)
11	61ST THRU 90TH DAY	ALL BUT \$248	\$248	\$0
12		A DAY	A DAY	
13	91ST DAY AND AFTER:			
14	—WHILE USING 60			
15	LIFETIME RESERVE DAYS	ALL BUT \$496	\$496	\$0
16		A DAY	A DAY	
17	—ONCE LIFETIME RESERVE			
18	DAYS ARE USED:			
19	—ADDITIONAL 365 DAYS	\$0	100% OF	\$0**
20			MEDICARE	
21			ELIGIBLE	
22			EXPENSES	
23	—BEYOND THE			
24	ADDITIONAL 365 DAYS	\$0	\$0	ALL COSTS
25	SKILLED NURSING FACILITY			
26	CARE*			
27	YOU MUST MEET MEDICARE'S			
28	REQUIREMENTS, INCLUDING			
29	HAVING BEEN IN A HOSPITAL			
30	FOR AT LEAST 3 DAYS AND			
31	ENTERED A MEDICARE-			



1	APPROVED FACILITY WITHIN			
2	30 DAYS AFTER LEAVING THE			
3	HOSPITAL			
4	FIRST 20 DAYS	ALL APPROVED	\$0	\$0
5		AMOUNTS		
6	21ST THRU 100TH DAY	ALL BUT \$124	UP TO \$124	\$0
7		A DAY	A DAY	
8	101ST DAY AND AFTER	\$0	\$0	ALL COSTS
9	BLOOD			
10	FIRST 3 PINTS	\$0	3 PINTS	\$0
11	ADDITIONAL AMOUNTS	100%	\$0	\$0
12	HOSPICE CARE			
13	YOU MUST MEET MEDICARE'S	ALL BUT VERY	MEDICARE	\$0
14	REQUIREMENTS, INCLUDING	LIMITED	COPAYMENT/	
15	A DOCTOR'S	COPAYMENT/	COINSURANCE	
16	CERTIFICATION OF	COINSURANCE		
17	TERMINAL ILLNESS	FOR OUTPATIENT		
18		DRUGS AND		
19		INPATIENT		
20		RESPIRE CARE		

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

28 PLAN M

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

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

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

1	BLOOD			
2	FIRST 3 PINTS	\$0	ALL COSTS	\$0
3	NEXT \$131 OF MEDICARE			
4	APPROVED AMOUNTS*	\$0	\$0	\$131
5				(PART B
6				DEDUC-
7				TIBLE)
8	REMAINDER OF MEDICARE			
9	APPROVED AMOUNTS	80%	20%	\$0
10	CLINICAL LABORATORY			
11	SERVICES—TESTS FOR			
12	DIAGNOSTIC SERVICES	100%	\$0	\$0

13 PARTS A & B

14	HOME HEALTH CARE			
15	MEDICARE APPROVED			
16	SERVICES			
17	—MEDICALLY NECESSARY			
18	SKILLED CARE SERVICES			
19	AND MEDICAL SUPPLIES	100%	\$0	\$0
20	—DURABLE MEDICAL			
21	EQUIPMENT			
22	FIRST \$131 OF			
23	MEDICARE APPROVED			
24	AMOUNTS	\$0	\$0	\$131
25				(PART B
26				DEDUC-
27				TIBLE)
28	REMAINDER OF MEDICARE			
29	APPROVED AMOUNTS	80%	20%	\$0

## OTHER BENEFITS—NOT COVERED BY MEDICARE

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

1	SERVICES AND SUPPLIES			
2	FIRST 60 DAYS	ALL BUT \$992	\$992	\$0
3			(PART A	
4			DEDUC-	
5			TIBLE)	
6	61ST THRU 90TH DAY	ALL BUT \$248	\$248	\$0
7		A DAY	A DAY	
8	91ST DAY AND AFTER:			
9	—WHILE USING 60			
10	LIFETIME RESERVE DAYS	ALL BUT \$496	\$496	\$0
11		A DAY	A DAY	
12	—ONCE LIFETIME RESERVE			
13	DAYS ARE USED:			
14	—ADDITIONAL 365 DAYS	\$0	100% OF	\$0**
15			MEDICARE	
16			ELIGIBLE	
17			EXPENSES	
18	—BEYOND THE			
19	ADDITIONAL 365 DAYS	\$0	\$0	ALL COSTS
20	SKILLED NURSING FACILITY			
21	CARE*			
22	YOU MUST MEET MEDICARE'S			
23	REQUIREMENTS, INCLUDING			
24	HAVING BEEN IN A HOSPITAL			
25	FOR AT LEAST 3 DAYS AND			
26	ENTERED A MEDICARE-			
27	APPROVED FACILITY WITHIN			
28	30 DAYS AFTER LEAVING THE			
29	HOSPITAL			
30	FIRST 20 DAYS	ALL APPROVED	\$0	\$0
31		AMOUNTS		

1	21ST THRU 100TH DAY	ALL BUT \$124	UP TO \$124	\$0
2		A DAY	A DAY	
3	101ST DAY AND AFTER	\$0	\$0	ALL COSTS
4	BLOOD			
5	FIRST 3 PINTS	\$0	3 PINTS	\$0
6	ADDITIONAL AMOUNTS	100%	\$0	\$0
7	HOSPICE CARE			
8	YOU MUST MEET MEDICARE'S	ALL BUT VERY	MEDICARE	\$0
9	REQUIREMENTS, INCLUDING	LIMITED	COPAYMENT/	
10	A DOCTOR'S CERTIFICATION	COPAYMENT/	COINSURANCE	
11	OF TERMINAL ILLNESS	COINSURANCE		
12		FOR OUTPATIENT		
13		DRUGS AND		
14		INPATIENT		
15		RESPIRE CARE		

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

23 PLAN N

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

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

1	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
2	MEDICAL EXPENSES—			
3	IN OR OUT OF THE			
4	HOSPITAL AND OUTPATIENT			
5	HOSPITAL TREATMENT, SUCH			
6	AS PHYSICIAN'S SERVICES,			
7	INPATIENT AND OUTPATIENT			
8	MEDICAL AND SURGICAL			
9	SERVICES AND SUPPLIES,			
10	PHYSICAL AND SPEECH			
11	THERAPY, DIAGNOSTIC			
12	TESTS, DURABLE MEDICAL			
13	EQUIPMENT			
14	FIRST \$131 OF MEDICARE			
15	APPROVED AMOUNTS*	\$0	\$0	\$131
16				(PART B
17				DEDUC-
18				TIBLE)
19	REMAINDER OF MEDICARE			
20	APPROVED AMOUNTS	GENERALLY	BALANCE,	UP TO \$20
21		80%	OTHER THAN	PER OFFICE
22			UP TO \$20	VISIT AND
23			PER OFFICE	UP TO \$50
24			VISIT AND	PER
25			UP TO \$50	EMERGENCY
26			PER	ROOM
27			EMERGENCY	VISIT. THE
28			ROOM VISIT.	COPAYMENT
29			THE	OF UP TO

1			COPAYMENT	\$50 IS
2			OF UP TO	WAIVED IF
3			\$50 IS	THE
4			WAIVED IF	INSURED IS
5			THE INSURED	ADMITTED
6			IS ADMITTED	TO ANY
7			TO ANY	HOSPITAL
8			HOSPITAL	AND THE
9			AND THE	EMERGENCY
10			EMERGENCY	VISIT IS
11			VISIT IS	COVERED AS
12			COVERED AS	A MEDICARE
13			A MEDICARE	PART A
14			PART A	EXPENSE.
15			EXPENSE.	
16	PART B EXCESS CHARGES			
17	(ABOVE MEDICARE			
18	APPROVED AMOUNTS)	\$0	\$0	ALL COSTS
19	BLOOD			
20	FIRST 3 PINTS	\$0	ALL COSTS	\$0
21	NEXT \$131 OF MEDICARE			
22	APPROVED AMOUNTS*	\$0	\$0	\$131
23				(PART B
24				DEDUC-
25				TIBLE)
26	REMAINDER OF MEDICARE			
27	APPROVED AMOUNTS	80%	20%	\$0
28	CLINICAL LABORATORY			
29	SERVICES—TESTS FOR			
30	DIAGNOSTIC SERVICES	100%	\$0	\$0



1 PARTS A & B

2	HOME HEALTH CARE			
3	MEDICARE APPROVED			
4	SERVICES			
5	—MEDICALLY NECESSARY			
6	SKILLED CARE SERVICES			
7	AND MEDICAL SUPPLIES	100%	\$0	\$0
8	—DURABLE MEDICAL			
9	EQUIPMENT			
10	FIRST \$131 OF			
11	MEDICARE APPROVED			
12	AMOUNTS*	\$0	\$0	\$131
13				(PART B
14				DEDUC-
15				TIBLE)
16	REMAINDER OF MEDICARE			
17	APPROVED AMOUNTS	80%	20%	\$0

18 OTHER BENEFITS—NOT COVERED BY MEDICARE

19	FOREIGN TRAVEL—NOT			
20	COVERED BY MEDICARE			
21	MEDICALLY NECESSARY			
22	EMERGENCY CARE SERVICES			
23	BEGINNING DURING THE			
24	FIRST 60 DAYS OF EACH			
25	TRIP OUTSIDE THE USA			
26	FIRST \$250 EACH			
27	CALENDAR YEAR	\$0	\$0	\$250
28	REMAINDER OF CHARGES	\$0	80% TO A	20% AND
29			LIFETIME	AMOUNTS

1			<b>MAXIMUM</b>	<b>OVER THE</b>
2			<b>BENEFIT OF</b>	<b>\$50,000</b>
3			<b>\$50,000</b>	<b>LIFETIME</b>
4				<b>MAXIMUM</b>

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

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

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

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

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

1 modified to correspond with such changes.

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

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

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

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

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

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

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

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

5 (b) Reinstated coverage shall be substantially equivalent  
6 to coverage in effect before the date of the suspension. If the  
7 suspended medicare supplement policy provided coverage for  
8 outpatient prescription drugs, reinstitution of the policy for  
9 medicare part D enrollees shall be without coverage for  
10 outpatient prescription drugs and shall otherwise provide  
11 substantially equivalent coverage to the coverage in effect  
12 before the date of the suspension.

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

18 (4) IF AN INSURER MAKES A WRITTEN OFFER TO THE MEDICARE  
19 SUPPLEMENT POLICYHOLDERS OR CERTIFICATE HOLDERS OF 1 OR MORE OF  
20 ITS PLANS, TO EXCHANGE DURING A SPECIFIED PERIOD FROM HIS OR HER  
21 1990 STANDARDIZED PLAN TO A 2010 STANDARDIZED PLAN, THE OFFER AND  
22 SUBSEQUENT EXCHANGE SHALL COMPLY WITH THE FOLLOWING REQUIREMENTS:

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

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

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

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

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

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

24 SEC. 3819A. (1) THIS SECTION APPLIES TO ALL MEDICARE  
25 SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR ISSUED FOR  
26 DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1,  
27 2010.

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

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

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

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

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

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

27           (E) TERMINATION OF A MEDICARE SUPPLEMENT POLICY SHALL NOT

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

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

13 (4) A MEDICARE SUPPLEMENT POLICY SHALL PROVIDE THAT BENEFITS  
14 AND PREMIUMS UNDER THE POLICY SHALL BE SUSPENDED AT THE REQUEST  
15 OF THE POLICYHOLDER OR CERTIFICATE HOLDER FOR A PERIOD NOT TO  
16 EXCEED 24 MONTHS IN WHICH THE POLICYHOLDER OR CERTIFICATE HOLDER  
17 HAS APPLIED FOR AND IS DETERMINED TO BE ENTITLED TO MEDICAL  
18 ASSISTANCE UNDER MEDICAID, BUT ONLY IF THE POLICYHOLDER OR  
19 CERTIFICATE HOLDER NOTIFIES THE INSURER OF SUCH ASSISTANCE WITHIN  
20 90 DAYS AFTER THE DATE THE INDIVIDUAL BECOMES ENTITLED TO THE  
21 ASSISTANCE. UPON RECEIPT OF TIMELY NOTICE, THE INSURER SHALL  
22 RETURN TO THE POLICYHOLDER OR CERTIFICATE HOLDER THAT PORTION OF  
23 THE PREMIUM ATTRIBUTABLE TO THE PERIOD OF MEDICAID ELIGIBILITY,  
24 SUBJECT TO ADJUSTMENT FOR PAID CLAIMS. IF A SUSPENSION OCCURS AND  
25 IF THE POLICYHOLDER OR CERTIFICATE HOLDER LOSES ENTITLEMENT TO  
26 MEDICAL ASSISTANCE UNDER MEDICAID, THE POLICY SHALL BE  
27 AUTOMATICALLY REINSTITUTED EFFECTIVE AS OF THE DATE OF



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

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

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

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

1 **COVERAGE NOT BEEN SUSPENDED.**

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

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

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

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

1 this section.

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

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

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

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

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

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

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

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

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

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

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

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

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