HOUSE BILL No. 4811

May 25, 1993, Introduced by Reps. Pitoniak, Agee, Gubow, Ciaramitaro, Kilpatrick, Gire, Rocca, Clack, Curtis and Profit and referred to the Committee on Insurance.

A bill to amend section 202 of Act No. 350 of the Public Acts of 1980, entitled as amended "The nonprofit health care corporation reform act," as amended by Act No. 102 of the Public Acts of 1988, being section 550.1202 of the Michigan Compiled Laws; to add part 4A; and to repeal certain parts of the act.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Section 202 of Act No. 350 of the Public Acts of 1980, as amended by Act No. 102 of the Public Acts of 1988, being section 550.1202 of the Michigan Compiled Laws, is amended and part 4A is added to read as follows:

Sec. 202. (1) Persons associating to form a health care corporation under this act shall subscribe to articles of incorporation that shall contain all of the following:

(a) The names and addresses of the incorporators.

(b) The location of the principal office of the corporation for the transaction of business in this state.

(c) The name by which the corporation shall be known and all assumed names under which the corporation does business. The corporate name shall not include the words insurance, casualty, surety, health and accident, mutual, or other words descriptive of the insurance or surety business, and shall not be so similar to the name of an insurance or surety company doing business in this or other states at the time of incorporation so as to tend, in the judgment of the commissioner, to create confusion in identity with that insurance or surety company.

(d) The purposes of the corporation, which shall be:

(*i*) To provide health care benefits.

(*ii*) To secure for all of the people of this state who apply for a certificate the opportunity for access to coverage for health care services at a fair and reasonable price.

(*iii*) To assure for nongroup and group subscribers reasonable access to, and reasonable cost and quality of, health care services.

(*iv*) To achieve the goals of the corporation relative to access, quality, and cost of health care services, as prescribed in section 504.

(*v*) To offer supplemental coverage to all medicare enrollees as provided in ~~section 411~~ PART 4A.

(*vi*) If under contract to serve as fiscal intermediary for the federal medicare program, to do all of the following:

(A) Carry out its contractual responsibilities efficiently, including the timely processing and payment of claims.

(B) Actively represent, in negotiations with the federal government and with providers of medical, hospital, and other health services for which benefits are provided under the federal medicare program, the interests of senior citizens as they relate to cost and quality of, and access to, health care services and administration of the program.

(*vii*) To engage in activity otherwise authorized by this act, within the purposes for which corporations may be organized under this act.

(e) The term of existence of the corporation, which may be in perpetuity.

(f) The time for the holding of the annual meeting of the corporation.

(g) Other terms and conditions not inconsistent with this act, necessary for the conduct of the affairs of the corporation.

(2) The articles shall be in triplicate and upon proper forms as prescribed by the commissioner.

(3) Before the articles or amendments to the articles are effective for any purpose, they shall be submitted to the attorney general for examination. If the attorney general finds the articles or amendments to the articles to be in compliance with this act, the attorney general shall certify this finding to the commissioner. The articles or amendments shall be effective at the time certified by the attorney general.

(4) Each health care corporation shall pay a fee of $250.00 to the attorney general for the examination of its articles of incorporation, or $100.00 for the examination of amendments to the articles of incorporation. Each health care corporation shall pay a filing fee of $100.00 to the commissioner for filing its articles of incorporation or $50.00 for the filing of amendments to the articles of incorporation. The fees prescribed in this subsection shall be deposited in the state treasury and credited to the general fund of the state.

PART 4A

MEDICARE SUPPLEMENT CERTIFICATES

SEC. 451. AS USED IN THIS PART:

(A) "APPLICANT" MEANS:

(*i*) FOR A NONGROUP MEDICARE SUPPLEMENT CERTIFICATE, THE PERSON WHO SEEKS TO CONTRACT FOR BENEFITS.

(*ii*) FOR A GROUP MEDICARE SUPPLEMENT CERTIFICATE, THE PROPOSED CERTIFICATE HOLDER.

(B) "CERTIFICATE" MEANS ANY CERTIFICATE DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE UNDER A MEDICARE SUPPLEMENT CERTIFICATE.

(C) "CERTIFICATE FORM" MEANS THE FORM ON WHICH THE CERTIFICATE IS DELIVERED OR ISSUED FOR DELIVERY.

(D) "DIRECT RESPONSE SOLICITATION" MEANS SOLICITATION IN WHICH A HEALTH CARE CORPORATION REPRESENTATIVE DOES NOT CONTACT THE APPLICANT IN PERSON AND EXPLAIN THE COVERAGE AVAILABLE, SUCH AS, BUT NOT LIMITED TO, SOLICITATION THROUGH DIRECT MAIL OR THROUGH ADVERTISEMENTS IN PERIODICALS AND OTHER MEDIA.

(E) "MEDICAID" MEANS TITLE XIX OF THE SOCIAL SECURITY ACT, CHAPTER 531, 49 STAT. 620, 42 U.S.C. 1396 TO 1396f, AND 1396i TO 1396u.

(F) "MEDICARE" MEANS TITLE XVIII OF THE SOCIAL SECURITY ACT, CHAPTER 531, 49 STAT. 620, 42 U.S.C. 1395 TO 1395b, 1395b-2, 1395c TO 1395i, 1395i-2 TO 1395i-4, 1395j TO 1395t, 1395u TO 1395w-2, AND 1395w-4 TO 1395ccc.

(G) "MEDICARE SUPPLEMENT BUYER'S GUIDE" MEANS THE DOCUMENT ENTITLED, "GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE", DEVELOPED BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AND THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES OR A SUBSTANTIALLY SIMILAR DOCUMENT AS APPROVED BY THE COMMISSIONER.

(H) "MEDICARE SUPPLEMENT CERTIFICATE" MEANS A NONGROUP OR GROUP CERTIFICATE THAT IS ADVERTISED, MARKETED, OR DESIGNED PRIMARILY AS A SUPPLEMENT TO REIMBURSEMENTS UNDER MEDICARE FOR THE HOSPITAL, MEDICAL, OR SURGICAL EXPENSES OF PERSONS ELIGIBLE FOR MEDICARE AND MEDICARE SELECT CERTIFICATES UNDER SECTION 467. MEDICARE SUPPLEMENT CERTIFICATE DOES NOT INCLUDE A CERTIFICATE OF 1 OR MORE EMPLOYERS OR LABOR ORGANIZATIONS, OR OF THE TRUSTEES OF A FUND ESTABLISHED BY 1 OR MORE EMPLOYERS OR LABOR ORGANIZATIONS, OR BOTH, FOR EMPLOYEES OR FORMER EMPLOYEES, OR BOTH, OR FOR MEMBERS OR FORMER MEMBERS, OR BOTH, OF THE LABOR ORGANIZATIONS.

SEC. 452. (1) EXCEPT AS PROVIDED IN SUBSECTION (2), THIS PART APPLIES TO A MEDICARE SUPPLEMENT CERTIFICATE DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE ON OR AFTER THE EFFECTIVE DATE OF THIS PART.

(2) SECTIONS 459, 461, AND 469(1) DO NOT APPLY TO A MEDICARE SUPPLEMENT CERTIFICATE ISSUED BEFORE THE EFFECTIVE DATE OF THIS PART.

SEC. 453. AS USED IN A MEDICARE SUPPLEMENT CERTIFICATE:

(A) THE DEFINITION OF "ACCIDENT", "ACCIDENTAL INJURY", OR "ACCIDENTAL MEANS" SHALL NOT INCLUDE WORDS THAT ESTABLISH AN ACCIDENTAL MEANS TEST OR USE WORDS SUCH AS "EXTERNAL, VIOLENT, VISIBLE WOUNDS" OR SIMILAR WORDS OF DESCRIPTION OR CHARACTERIZATION. THE DEFINITION MAY PROVIDE THAT INJURIES SHALL NOT INCLUDE INJURIES FOR WHICH BENEFITS ARE PROVIDED OR AVAILABLE UNDER ANY WORKER'S COMPENSATION, EMPLOYER'S LIABILITY OR SIMILAR LAW, OR MOTOR VEHICLE NO-FAULT PLAN, UNLESS PROHIBITED BY LAW.

(B) THE DEFINITION OF "BENEFIT PERIOD" OR "MEDICARE BENEFIT PERIOD" SHALL NOT BE DEFINED IN A MORE RESTRICTIVE MANNER THAN AS DEFINED IN MEDICARE.

(C) "HOSPITAL" MAY BE DEFINED IN RELATION TO ITS STATUS, FACILITIES, AND AVAILABLE SERVICES OR TO REFLECT ITS ACCREDITATION BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, BUT NOT MORE RESTRICTIVELY THAN AS DEFINED IN MEDICARE.

(D) THE DEFINITION OF "MEDICARE ELIGIBLE EXPENSES" SHALL MEAN HEALTH CARE EXPENSES OF THE KINDS COVERED BY MEDICARE, TO THE EXTENT RECOGNIZED AS REASONABLE AND MEDICALLY NECESSARY BY MEDICARE.

(E) "NURSES" MAY BE DEFINED SO THAT THE DESCRIPTION OF NURSE IS TO A TYPE OF NURSE, SUCH AS A REGISTERED PROFESSIONAL NURSE OR A LICENSED PRACTICAL NURSE. IF THE WORDS "NURSE", "TRAINED NURSE", OR "REGISTERED NURSE" ARE USED WITHOUT SPECIFIC

INSTRUCTION, THEN THE USE OF THOSE TERMS REQUIRES THE HEALTH CARE CORPORATION TO RECOGNIZE THE SERVICES OF ANY INDIVIDUAL WHO QUALIFIES UNDER THOSE TERMS IN ACCORDANCE WITH THE PUBLIC HEALTH CODE, ACT NO. 368 OF THE PUBLIC ACTS OF 1978, BEING SECTIONS 333.1101 TO 333.25211 OF THE MICHIGAN COMPILED LAWS.

(F) "PHYSICIAN" SHALL NOT BE DEFINED MORE RESTRICTIVELY THAN AS DEFINED IN MEDICARE.

(G) "SICKNESS" SHALL NOT BE DEFINED MORE RESTRICTIVELY THAN TO MEAN ILLNESS OR DISEASE OF A COVERED PERSON THAT FIRST MANIFESTS ITSELF AFTER THE EFFECTIVE DATE OF COVERAGE AND WHILE THE COVERAGE IS IN FORCE. THE DEFINITION MAY BE FURTHER MODIFIED TO EXCLUDE SICKNESSES OR DISEASES FOR WHICH BENEFITS ARE PROVIDED TO THE MEMBER UNDER ANY WORKER'S COMPENSATION, OCCUPATIONAL DISEASE, EMPLOYER'S LIABILITY, OR SIMILAR LAW.

(H) "SKILLED NURSING FACILITY" SHALL NOT BE DEFINED MORE RESTRICTIVELY THAN AS DEFINED IN MEDICARE.

SEC. 455. EVERY HEALTH CARE CORPORATION ISSUING A MEDICARE SUPPLEMENT CERTIFICATE IN THIS STATE SHALL MAKE AVAILABLE A MEDICARE SUPPLEMENT CERTIFICATE THAT INCLUDES ONLY A BASIC CORE PACKAGE OF BENEFITS TO EACH PROSPECTIVE MEMBER. A HEALTH CARE CORPORATION ISSUING A MEDICARE SUPPLEMENT CERTIFICATE IN THIS STATE MAY MAKE AVAILABLE TO PROSPECTIVE MEMBERS BENEFITS PURSUANT TO SECTION 459 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 THE MEDICARE PART A ELIGIBLE EXPENSES FOR HOSPITALIZATION PAID AT THE DIAGNOSTIC RELATED GROUP DAY OUTLIER PER DIEM OR OTHER APPROPRIATE 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 OF MEDICARE ELIGIBLE EXPENSES UNDER PART B REGARDLESS OF HOSPITAL CONFINEMENT, SUBJECT TO THE MEDICARE PART B DEDUCTIBLE.

SEC. 457. EVERY HEALTH CARE CORPORATION ISSUING A MEDICARE SUPPLEMENT CERTIFICATE IN THIS STATE SHALL MAKE AVAILABLE A MEDICARE SUPPLEMENT CERTIFICATE THAT INCLUDES THE BENEFITS PROVIDED IN SECTION 461(5)(C).

SEC. 459. (1) IN ADDITION TO THE BASIC CORE PACKAGE OF BENEFITS REQUIRED UNDER SECTION 455, THE FOLLOWING BENEFITS MAY BE INCLUDED IN A MEDICARE SUPPLEMENT CERTIFICATE AND IF INCLUDED SHALL CONFORM TO SECTION 461(5)(B) TO (J):

(A) MEDICARE PART A DEDUCTIBLE: COVERAGE FOR ALL OF THE MEDICARE PART A INPATIENT HOSPITAL DEDUCTIBLE AMOUNT PER BENEFIT PERIOD.

(B) SKILLED NURSING FACILITY CARE: COVERAGE FOR THE ACTUAL BILLED CHARGES UP TO THE COINSURANCE AMOUNT FROM THE 21ST DAY THROUGH THE 100TH DAY IN A MEDICARE BENEFIT PERIOD FOR POSTHOSPITAL SKILLED NURSING FACILITY CARE ELIGIBLE UNDER MEDICARE PART A.

(C) MEDICARE PART B DEDUCTIBLE: COVERAGE FOR ALL OF THE MEDICARE PART B DEDUCTIBLE AMOUNT PER CALENDAR YEAR REGARDLESS OF HOSPITAL CONFINEMENT.

(D) EIGHTY PERCENT OF THE MEDICARE PART B EXCESS CHARGES: COVERAGE FOR 80% OF THE DIFFERENCE BETWEEN THE ACTUAL MEDICARE PART B CHARGE AS BILLED, NOT TO EXCEED ANY CHARGE LIMITATION ESTABLISHED BY MEDICARE OR STATE LAW, AND THE MEDICARE-APPROVED PART B CHARGE.

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

(F) BASIC OUTPATIENT PRESCRIPTION DRUG BENEFIT: COVERAGE FOR 50% OF OUTPATIENT PRESCRIPTION DRUG CHARGES, AFTER A $250.00 CALENDAR YEAR DEDUCTIBLE, TO A MAXIMUM OF $1,250.00 IN BENEFITS RECEIVED BY THE MEMBER PER CALENDAR YEAR, TO THE EXTENT NOT COVERED BY MEDICARE.

(G) EXTENDED OUTPATIENT PRESCRIPTION DRUG BENEFIT: COVERAGE FOR 50% OF OUTPATIENT PRESCRIPTION DRUG CHARGES, AFTER A $250.00 CALENDAR YEAR DEDUCTIBLE, TO A MAXIMUM OF $3,000.00 IN BENEFITS RECEIVED BY THE MEMBER PER CALENDAR YEAR, TO THE EXTENT NOT COVERED BY MEDICARE.

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

(I) PREVENTIVE MEDICAL CARE BENEFIT: COVERAGE FOR THE FOLLOWING PREVENTIVE HEALTH SERVICES:

(*i*) AN ANNUAL CLINICAL PREVENTIVE MEDICAL HISTORY AND PHYSICAL EXAMINATION THAT MAY INCLUDE TESTS AND SERVICES FROM SUBPARAGRAPH (*ii*) AND PATIENT EDUCATION TO ADDRESS PREVENTIVE HEALTH CARE MEASURES.

(*ii*) ANY 1 OR A COMBINATION OF THE FOLLOWING PREVENTIVE SCREENING TESTS OR PREVENTIVE SERVICES, THE FREQUENCY OF WHICH IS CONSIDERED MEDICALLY APPROPRIATE:

(A) FECAL OCCULT BLOOD TEST AND DIGITAL RECTAL EXAMINATION.

(B) MAMMOGRAM.

(C) DIPSTICK URINALYSIS FOR HEMATURIA, BACTERIURIA, AND PROTEINURIA.

(D) PURE TONE, AIR ONLY, HEARING SCREENING TEST, ADMINISTERED OR ORDERED BY A PHYSICIAN.

(E) SERUM CHOLESTEROL SCREENING EVERY 5 YEARS.

(F) THYROID FUNCTION TEST.

(G) DIABETES SCREENING.

(H) INFLUENZA VACCINE ADMINISTERED AT ANY APPROPRIATE TIME DURING THE YEAR AND TETANUS AND DIPHTHERIA BOOSTER EVERY 10 YEARS.

(I) ANY OTHER TESTS OR PREVENTIVE MEASURES DETERMINED APPROPRIATE BY THE ATTENDING PHYSICIAN.

(J) AT-HOME RECOVERY BENEFIT: COVERAGE FOR SERVICES TO PROVIDE SHORT TERM, AT-HOME ASSISTANCE WITH ACTIVITIES OF DAILY LIVING FOR THOSE RECOVERING FROM AN ILLNESS, INJURY, OR SURGERY. AT-HOME RECOVERY SERVICES PROVIDED SHALL BE PRIMARILY SERVICES THAT ASSIST IN ACTIVITIES OF DAILY LIVING. THE MEMBER'S ATTENDING PHYSICIAN SHALL CERTIFY THAT THE SPECIFIC TYPE AND FREQUENCY OF AT-HOME RECOVERY SERVICES ARE NECESSARY BECAUSE OF A CONDITION FOR WHICH A HOME CARE PLAN OF TREATMENT WAS APPROVED BY MEDICARE. COVERAGE IS EXCLUDED FOR HOME CARE VISITS PAID FOR BY MEDICARE OR OTHER GOVERNMENT PROGRAMS AND CARE PROVIDED BY FAMILY MEMBERS, UNPAID VOLUNTEERS, OR PROVIDERS WHO ARE NOT CARE PROVIDERS. COVERAGE IS LIMITED TO:

(*i*) NO MORE THAN THE NUMBER OF AT-HOME RECOVERY VISITS CERTIFIED AS NECESSARY BY THE MEMBER'S ATTENDING PHYSICIAN. THE TOTAL NUMBER OF AT-HOME RECOVERY VISITS SHALL NOT EXCEED THE NUMBER OF MEDICARE APPROVED HOME HEALTH CARE VISITS UNDER A MEDICARE APPROVED HOME CARE PLAN OF TREATMENT.

(*ii*) THE ACTUAL CHARGES FOR EACH VISIT UP TO A MAXIMUM REIMBURSEMENT OF $40.00 PER VISIT.

(*iii*) ONE THOUSAND SIX HUNDRED DOLLARS PER CALENDAR YEAR.

(*iv*) SEVEN VISITS IN ANY 1 WEEK.

(*v*) CARE FURNISHED ON A VISITING BASIS IN THE MEMBER'S HOME.

(*vi*) SERVICES PROVIDED BY A CARE PROVIDER AS DEFINED IN THIS SECTION.

(*vii*) AT-HOME RECOVERY VISITS WHILE THE MEMBER IS COVERED UNDER THE CERTIFICATE AND NOT OTHERWISE EXCLUDED.

(*viii*) AT-HOME RECOVERY VISITS RECEIVED DURING THE PERIOD THE MEMBER IS RECEIVING MEDICARE APPROVED HOME CARE SERVICES OR NO MORE THAN 8 WEEKS AFTER THE SERVICE DATE OF THE LAST MEDICARE APPROVED HOME HEALTH CARE VISIT.

(K) NEW OR INNOVATIVE BENEFITS: A HEALTH CARE CORPORATION MAY, WITH THE PRIOR APPROVAL OF THE COMMISSIONER, OFFER NEW OR INNOVATIVE BENEFITS IN ADDITION TO THE BENEFITS PROVIDED IN A CERTIFICATE THAT OTHERWISE COMPLIES WITH THE APPLICABLE STANDARDS. THESE BENEFITS MAY INCLUDE BENEFITS THAT ARE APPROPRIATE TO MEDICARE SUPPLEMENT COVERAGE, NEW OR INNOVATIVE, NOT OTHERWISE AVAILABLE, COST-EFFECTIVE, AND OFFERED IN A MANNER THAT

IS CONSISTENT WITH THE GOAL OF SIMPLIFICATION OF MEDICARE SUPPLEMENT CERTIFICATES.

(2) REIMBURSEMENT FOR THE PREVENTIVE SCREENING TESTS AND SERVICES UNDER SUBSECTION (1)(I)(*ii*) SHALL BE FOR THE ACTUAL CHARGES UP TO 100% OF THE MEDICARE-APPROVED AMOUNT FOR EACH TEST OR SERVICE, AS IF MEDICARE WERE TO COVER THE TEST OR SERVICE AS IDENTIFIED IN THE AMERICAN MEDICAL ASSOCIATION CURRENT PROCEDURAL TERMINOLOGY CODES, TO A MAXIMUM OF $120.00 ANNUALLY UNDER THIS BENEFIT. THIS BENEFIT SHALL NOT INCLUDE PAYMENT FOR ANY PROCEDURE COVERED BY MEDICARE.

(3) AS USED IN SUBSECTION (1)(J):

(A) "ACTIVITIES OF DAILY LIVING" INCLUDE, BUT ARE NOT LIMITED TO, BATHING, DRESSING, PERSONAL HYGIENE, TRANSFERRING, EATING, AMBULATING, ASSISTANCE WITH DRUGS THAT ARE NORMALLY SELF-ADMINISTERED, AND CHANGING BANDAGES OR OTHER DRESSINGS.

(B) "CARE PROVIDER" MEANS A DULY QUALIFIED OR LICENSED HOME HEALTH AIDE/HOMEMAKER, PERSONAL CARE AIDE, OR NURSE PROVIDED THROUGH A LICENSED HOME HEALTH CARE AGENCY OR REFERRED BY A LICENSED REFERRAL AGENCY OR LICENSED NURSES REGISTRY.

(C) "HOME" MEANS ANY PLACE USED BY THE MEMBER AS A PLACE OF RESIDENCE, PROVIDED THAT IT QUALIFIES AS A RESIDENCE FOR HOME HEALTH CARE SERVICES COVERED BY MEDICARE. A HOSPITAL OR SKILLED NURSING FACILITY SHALL NOT BE CONSIDERED THE MEMBER'S HOME.

(D) "AT-HOME RECOVERY VISIT" MEANS THE PERIOD OF A VISIT REQUIRED TO PROVIDE AT HOME RECOVERY CARE, WITHOUT LIMIT ON THE DURATION OF THE VISIT, EXCEPT EACH CONSECUTIVE 4 HOURS IN A

24-HOUR PERIOD OF SERVICES PROVIDED BY A CARE PROVIDER IS 1 VISIT.

SEC. 461. (1) A HEALTH CARE CORPORATION SHALL MAKE AVAILABLE TO EACH PROSPECTIVE MEDICARE SUPPLEMENT CERTIFICATE HOLDER A CERTIFICATE FORM CONTAINING ONLY THE BASIC CORE BENEFITS AS PROVIDED IN SECTION 455.

(2) GROUPS, PACKAGES, OR COMBINATIONS OF MEDICARE SUPPLEMENT BENEFITS OTHER THAN THOSE LISTED IN THIS SECTION SHALL NOT BE OFFERED FOR SALE IN THIS STATE EXCEPT AS MAY BE PERMITTED IN SECTION 459(1)(K).

(3) BENEFIT PLANS SHALL CONTAIN THE APPROPRIATE A THROUGH J DESIGNATIONS, SHALL BE UNIFORM IN STRUCTURE, LANGUAGE, AND FORMAT TO THE STANDARD BENEFIT PLANS IN SUBSECTION (5), AND SHALL CONFORM TO THE DEFINITIONS IN THIS PART. EACH BENEFIT SHALL BE STRUCTURED IN ACCORDANCE WITH SECTIONS 455 AND 459 AND LIST THE BENEFITS IN THE ORDER SHOWN IN SUBSECTION (5). FOR PURPOSES OF THIS SECTION, "STRUCTURE, LANGUAGE, AND FORMAT" MEANS STYLE, ARRANGEMENT, AND OVERALL CONTENT OF A BENEFIT.

(4) IN ADDITION TO THE BENEFIT PLAN DESIGNATIONS A THROUGH J AS PROVIDED UNDER SUBSECTION (5), A HEALTH CARE CORPORATION MAY USE OTHER DESIGNATIONS TO THE EXTENT PERMITTED BY LAW.

(5) A MEDICARE SUPPLEMENT BENEFIT PLAN SHALL CONFORM TO 1 OF THE FOLLOWING:

(A) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN A SHALL BE LIMITED TO THE BASIC CORE BENEFITS COMMON TO ALL BENEFIT PLANS AS DEFINED IN SECTION 455.

(B) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN B SHALL INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SECTION 455 AND THE MEDICARE PART A DEDUCTIBLE AS DEFINED IN SECTION 459(1)(A).

(C) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN C SHALL INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SECTION 455, THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACILITY CARE, MEDICARE PART B DEDUCTIBLE, AND MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY AS DEFINED IN SECTION 459(1)(A), (B), (C), AND (H).

(D) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN D SHALL INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SECTION 455, THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACILITY CARE, MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY, AND THE AT-HOME RECOVERY BENEFIT AS DEFINED IN SECTION 459(1)(A), (B), (H), AND (J).

(E) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN E SHALL INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SECTION 455, THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACILITY CARE, MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY, AND PREVENTIVE MEDICAL CARE AS DEFINED IN SECTION 459(1)(A), (B), (H), AND (I).

(F) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN F SHALL INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SECTION 455, THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACILITY CARE, MEDICARE PART B DEDUCTIBLE, 100% OF THE MEDICARE PART B EXCESS CHARGES, AND MEDICALLY NECESSARY EMERGENCY CARE IN A

FOREIGN COUNTRY AS DEFINED IN SECTION 459(1)(A), (B), (C), (E), AND (H).

(G) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN G SHALL INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SECTION 455, THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACILITY CARE, 80% OF THE MEDICARE PART B EXCESS CHARGES, MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY, AND THE AT-HOME RECOVERY BENEFIT AS DEFINED IN SECTION 459(1)(A), (B), (D), (H), AND (J).

(H) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN H SHALL INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SECTION 455, THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACILITY CARE, BASIC OUTPATIENT PRESCRIPTION DRUG BENEFIT, AND MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY AS DEFINED IN SECTION 459(1)(A), (B), (F), AND (H).

(I) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN I SHALL INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SECTION 455, THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACILITY CARE, 100% OF THE MEDICARE PART B EXCESS CHARGES, BASIC OUTPATIENT PRESCRIPTION DRUG BENEFIT, MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY, AND AT-HOME RECOVERY BENEFIT AS DEFINED IN SECTION 459(1)(A), (B), (E), (F), (H), AND (J).

(J) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN J SHALL INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SECTION 455, THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACILITY CARE, MEDICARE PART B DEDUCTIBLE, 100% OF THE MEDICARE PART B EXCESS CHARGES, EXTENDED OUTPATIENT PRESCRIPTION DRUG BENEFIT,

MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY, PREVENTIVE MEDICAL CARE, AND AT-HOME RECOVERY BENEFIT AS DEFINED IN SECTION 459(1)(A), (B), (C), (E), (G), (H), (I), AND (J).

SEC. 463. A HEALTH CARE CORPORATION THAT ISSUES A CERTIFICATE THAT PROVIDES DISABILITY COVERAGE TO A PERSON ELIGIBLE FOR MEDICARE BY REASON OF AGE SHALL PROVIDE THE PROSPECTIVE CERTIFICATE HOLDER WITH A MEDICARE SUPPLEMENT BUYER'S GUIDE, WHICH SHALL BE FURNISHED AT THE TIME OF APPLICATION, AND ACKNOWLEDGMENT OF RECEIPT OF THE BUYER'S GUIDE SHALL BE OBTAINED BY THE HEALTH CARE CORPORATION. HOWEVER, FOR DIRECT RESPONSE SOLICITATION CERTIFICATES, THE GUIDE SHALL BE FURNISHED WITH THE CERTIFICATE AND ACKNOWLEDGMENT OF RECEIPT NEED NOT BE OBTAINED BY THE HEALTH CARE CORPORATION.

SEC. 465. (1) A HEALTH CARE CORPORATION THAT OFFERS A MEDICARE SUPPLEMENT CERTIFICATE SHALL PROVIDE AN OUTLINE OF COVERAGE TO THE APPLICANT AT THE TIME OF APPLICATION AND, EXCEPT FOR DIRECT RESPONSE SOLICITATION CERTIFICATES, SHALL OBTAIN AN ACKNOWLEDGMENT OF RECEIPT OF THE OUTLINE OF COVERAGE FROM THE APPLICANT. THE OUTLINE OF COVERAGE PROVIDED TO APPLICANTS PURSUANT TO THIS SECTION SHALL CONSIST OF THE FOLLOWING 4 PARTS:

(A) A COVER PAGE.

(B) PREMIUM INFORMATION.

(C) DISCLOSURE PAGES.

(D) CHARTS DISPLAYING THE FEATURES OF EACH BENEFIT PLAN OFFERED BY THE HEALTH CARE CORPORATION.

(2) IF AN OUTLINE OF COVERAGE IS PROVIDED AT THE TIME OF APPLICATION AND THE MEDICARE SUPPLEMENT CERTIFICATE IS ISSUED ON

A BASIS THAT WOULD REQUIRE REVISION OF THE OUTLINE, A SUBSTITUTE OUTLINE OF COVERAGE PROPERLY DESCRIBING THE CERTIFICATE SHALL BE DELIVERED WITH THE CERTIFICATE AND CONTAIN THE FOLLOWING STATEMENT, IN NO LESS THAN 12-POINT TYPE, IMMEDIATELY ABOVE THE COMPANY NAME:

NOTICE: READ THIS OUTLINE OF COVERAGE CAREFULLY. IT IS NOT IDENTICAL TO THE OUTLINE OF COVERAGE PROVIDED UPON APPLICATION AND THE COVERAGE ORIGINALLY APPLIED FOR HAS NOT BEEN ISSUED.

(3) AN OUTLINE OF COVERAGE UNDER SUBSECTION (1) OR (2) SHALL BE IN THE LANGUAGE AND FORMAT PRESCRIBED IN THIS SECTION AND IN NOT LESS THAN 12-POINT TYPE. THE A THROUGH J LETTER DESIGNATION OF THE PLAN SHALL BE SHOWN ON THE COVER PAGE AND THE PLANS OFFERED BY THE HEALTH CARE CORPORATION SHALL BE PROMINENTLY IDENTIFIED. PREMIUM INFORMATION SHALL BE SHOWN ON THE COVER PAGE OR IMMEDIATELY FOLLOWING THE COVER PAGE AND SHALL BE PROMINENTLY DISPLAYED. THE PREMIUM AND METHOD OF PAYMENT SHALL BE STATED FOR ALL PLANS THAT ARE OFFERED TO THE APPLICANT. ALL POSSIBLE PREMIUMS FOR THE APPLICANT SHALL BE ILLUSTRATED. THE FOLLOWING ITEMS SHALL BE INCLUDED IN THE OUTLINE OF COVERAGE IN THE ORDER PRESCRIBED BELOW AND IN SUBSTANTIALLY THE FOLLOWING FORM, AS APPROVED BY THE COMMISSIONER:

(HEALTH CARE CORPORATION NAME)
MEDICARE SUPPLEMENT COVERAGE
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE-COVER PAGE:
BENEFIT PLAN(S)_____ [INSERT LETTER(S) OF PLAN(S) BEING OFFERED]

MEDICARE SUPPLEMENT COVERAGE CAN BE SOLD IN ONLY 10 STANDARD PLANS. THIS CHART SHOWS THE BENEFITS INCLUDED IN EACH PLAN. EVERY HEALTH CARE CORPORATION SHALL MAKE AVAILABLE PLAN "A". SOME PLANS MAY NOT BE AVAILABLE IN YOUR STATE.

BASIC BENEFITS: INCLUDED IN ALL PLANS.

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

MEDICAL EXPENSES: PART B COINSURANCE (20% OF MEDICARE-APPROVED EXPENSES).

BLOOD: FIRST THREE PINTS OF BLOOD EACH YEAR.

	A	B	C	D	E	F	G	H	I	J
BASIC BENEFITS	X	X	X	X	X	X	X	X	X	X
SKILLED NURSING CO-INSURANCE			X	X	X	X	X	X	X	X
PART A DEDUCTIBLE		X	X	X	X	X	X	X	X	X
PART B DEDUCTIBLE			X			X				X
PART B EXCESS						X 100%	X 80%		X 100%	X 100%
FOREIGN TRAVEL EMERGENCY			X	X	X	X	X	X	X	X
AT-HOME RECOVERY				X			X		X	X
DRUGS								X $1,250 LIMIT	X $1,250 LIMIT	X $3,000 LIMIT

PREMIUM INFORMATION

WE (INSERT HEALTH CARE CORPORATION'S NAME) CAN ONLY RAISE YOUR PREMIUM IF WE RAISE THE PREMIUM FOR ALL CERTIFICATES LIKE YOURS IN THIS STATE. (IF THE PREMIUM IS BASED ON THE INCREASING AGE OF THE MEMBER, INCLUDE INFORMATION SPECIFYING WHEN PREMIUMS WILL CHANGE).

DISCLOSURES

USE THIS OUTLINE TO COMPARE BENEFITS AND PREMIUMS AMONG POLICIES, CERTIFICATES, AND CONTRACTS.

READ YOUR POLICY VERY CAREFULLY

THIS IS ONLY AN OUTLINE DESCRIBING YOUR CERTIFICATE'S MOST IMPORTANT FEATURES. THE CERTIFICATE IS YOUR CONTRACT. YOU MUST READ THE CERTIFICATE ITSELF TO UNDERSTAND ALL OF THE RIGHTS AND DUTIES OF BOTH YOU AND YOUR HEALTH CARE CORPORATION.

RIGHT TO RETURN CERTIFICATE

IF YOU FIND THAT YOU ARE NOT SATISFIED WITH YOUR CERTIFICATE, YOU MAY RETURN IT TO (INSERT HEALTH CARE CORPORATION'S ADDRESS). IF YOU SEND THE CERTIFICATE BACK TO US WITHIN 30 DAYS AFTER YOU RECEIVE IT, WE WILL TREAT THE CERTIFICATE AS IF IT HAD NEVER BEEN ISSUED AND RETURN ALL OF YOUR PAYMENTS.

CERTIFICATE REPLACEMENT

IF YOU ARE REPLACING ANOTHER HEALTH INSURANCE POLICY, CONTRACT, OR CERTIFICATE, DO NOT CANCEL IT UNTIL YOU HAVE ACTUALLY RECEIVED YOUR NEW CERTIFICATE AND ARE SURE YOU WANT TO KEEP IT.

NOTICE

THIS CERTIFICATE MAY NOT FULLY COVER ALL OF YOUR MEDICAL COSTS.

[FOR AGENT ISSUED CERTIFICATES]

NEITHER (INSERT HEALTH CARE CORPORATION'S NAME) NOR ITS AGENTS ARE CONNECTED WITH MEDICARE.

[FOR DIRECT RESPONSE ISSUED CERTIFICATES]

(INSERT HEALTH CARE CORPORATION'S NAME) IS NOT CONNECTED WITH MEDICARE.

THIS OUTLINE OF COVERAGE DOES NOT GIVE ALL THE DETAILS OF MEDICARE COVERAGE. CONTACT YOUR LOCAL SOCIAL SECURITY OFFICE OR CONSULT "THE MEDICARE HANDBOOK" FOR MORE DETAILS.

COMPLETE ANSWERS ARE VERY IMPORTANT

WHEN YOU FILL OUT THE APPLICATION FOR THE NEW CERTIFICATE, BE SURE TO ANSWER TRUTHFULLY AND COMPLETELY ALL QUESTIONS ABOUT YOUR MEDICAL AND HEALTH HISTORY. THE COMPANY MAY CANCEL YOUR CERTIFICATE AND REFUSE TO PAY ANY CLAIMS IF YOU LEAVE OUT OR FALSIFY IMPORTANT MEDICAL INFORMATION. [IF THE CERTIFICATE IS GUARANTEED ISSUE, THIS PARAGRAPH NEED NOT APPEAR.]

REVIEW THE APPLICATION CAREFULLY BEFORE YOU SIGN IT. BE CERTAIN THAT ALL INFORMATION HAS BEEN PROPERLY RECORDED.

[INCLUDE FOR EACH PLAN OFFERED BY THE HEALTH CARE CORPORATION A CHART SHOWING THE SERVICES, MEDICARE PAYMENTS, PLAN PAYMENTS, AND MEMBER PAYMENTS USING THE SAME LANGUAGE, IN THE SAME ORDER, AND USING UNIFORM LAYOUT AND FORMAT AS SHOWN IN THE CHARTS THAT FOLLOW. A HEALTH CARE CORPORATION MAY USE ADDITIONAL BENEFIT PLAN DESIGNATIONS ON THESE CHARTS PURSUANT TO SECTION 459(1)(K). INCLUDE AN EXPLANATION OF ANY INNOVATIVE BENEFITS ON THE COVER PAGE AND IN THE CHART, IN A MANNER APPROVED BY THE COMMISSIONER. THE HEALTH CARE CORPORATION ISSUING THE

CERTIFICATE SHALL CHANGE THE DOLLAR AMOUNTS EACH YEAR TO REFLECT CURRENT FIGURES. NO MORE THAN 4 PLANS MAY BE SHOWN ON 1 CHART.] CHARTS FOR EACH PLAN ARE AS FOLLOWS:

PLAN A

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

*A BENEFIT PERIOD BEGINS ON THE FIRST DAY YOU RECEIVE SERVICE AS AN INPATIENT IN A HOSPITAL AND ENDS AFTER YOU HAVE BEEN OUT OF THE HOSPITAL AND HAVE NOT RECEIVED SKILLED CARE IN ANY OTHER FACILITY FOR 60 DAYS IN A ROW.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* SEMIPRIVATE ROOM AND BOARD, GENERAL NURSING AND MISCELLANEOUS SERVICES AND SUPPLIES			
FIRST 60 DAYS	ALL BUT $628	$0	$628 (PART A DEDUCTIBLE)
61ST THRU 90TH DAY	ALL BUT $157 A DAY	$157 A DAY	$0
91ST DAY AND AFTER:			
--WHILE USING 60 LIFETIME RESERVE DAYS	ALL BUT $314 A DAY	$314 A DAY	$0
--ONCE LIFETIME RESERVE DAYS ARE USED:			
--ADDITIONAL 365 DAYS	$0	100% OF MEDICARE ELIGIBLE EXPENSES	$0
--BEYOND THE ADDITIONAL 365 DAYS	$0	$0	ALL COSTS
SKILLED NURSING FACILITY CARE* YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING HAVING BEEN IN A HOSPITAL FOR AT LEAST 3 DAYS AND ENTERED A MEDICARE-APPROVED FACILITY WITHIN 30 DAYS AFTER LEAVING THE HOSPITAL			
FIRST 20 DAYS	ALL APPROVED AMOUNTS	$0	$0
21ST THRU 100TH DAY	ALL BUT $78.50 A DAY	$0	UP TO $78.50 A DAY
101ST DAY AND AFTER	$0	$0	ALL COSTS
BLOOD			
FIRST 3 PINTS	$0	3 PINTS	$0
ADDITIONAL AMOUNTS	100%	$0	$0

HOSPICE CARE AVAILABLE AS LONG AS YOUR DOCTOR CERTIFIES YOU ARE TERMINALLY ILL AND YOU ELECT TO RECEIVE THESE SERVICES	ALL BUT VERY LIMITED COINSURANCE FOR OUTPATIENT DRUGS AND INPATIENT RESPITE CARE	$0	BALANCE

PLAN A

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

*ONCE YOU HAVE BEEN BILLED $100 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 PHYSI- CIAN'S SERVICES, INPATIENT AND OUTPATIENT MEDICAL AND SURGICAL SERVICES AND SUP- PLIES, PHYSICAL AND SPEECH THERAPY, DIAGNOSTIC TESTS, DURABLE MEDICAL EQUIPMENT,			
FIRST $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80% (GENERALLY)	20% (GENERALLY)	$0
PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)	$0	$0	ALL COSTS
BLOOD FIRST 3 PINTS	$0	ALL COSTS	$0
NEXT $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(CONTINUED)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--MEDICALLY NECESSARY SKILLED CARE SERVICES AND MEDICAL SUPPLIES	100%	$0	$0
--DURABLE MEDICAL EQUIPMENT			
FIRST $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0

PLAN B

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

*A BENEFIT PERIOD BEGINS ON THE FIRST DAY YOU RECEIVE SERVICE AS AN INPATIENT IN A HOSPITAL AND ENDS AFTER YOU HAVE BEEN OUT OF THE HOSPITAL AND HAVE NOT RECEIVED SKILLED CARE IN ANY OTHER FACILITY FOR 60 DAYS IN A ROW.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* SEMIPRIVATE ROOM AND BOARD, GENERAL NURSING AND MISCELLANEOUS SERVICES AND SUPPLIES			
FIRST 60 DAYS	ALL BUT $628	$628 (PART A DEDUCTIBLE)	$0
61ST THRU 90TH DAY	ALL BUT $157 A DAY	$157 A DAY	$0
91ST DAY AND AFTER			
--WHILE USING 60 LIFETIME RESERVE DAYS	ALL BUT $314 A DAY	$314 A DAY	$0
--ONCE LIFETIME RESERVE DAYS ARE USED:			
--ADDITIONAL 365 DAYS	$0	100% OF MEDICARE ELIGIBLE EXPENSES	$0
--BEYOND THE ADDITIONAL 365 DAYS	$0	$0	ALL COSTS
SKILLED NURSING FACILITY CARE* YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING HAVING BEEN IN A HOSPITAL FOR AT LEAST 3 DAYS AND ENTERED A MEDICARE-APPROVED FACILITY WITHIN 30 DAYS AFTER LEAVING THE HOSPITAL			
FIRST 20 DAYS	ALL APPROVED AMOUNTS	$0	$0
21ST THRU 100TH DAY	ALL BUT $78.50 A DAY	$0	UP TO $78.50 A DAY
101ST DAY AND AFTER	$0	$0	ALL COSTS
BLOOD			
FIRST 3 PINTS	$0	3 PINTS	$0
ADDITIONAL AMOUNTS	100%	$0	$0

HOSPICE CARE AVAILABLE AS LONG AS YOUR DOCTOR CERTIFIES YOU ARE TERMINALLY ILL AND YOU ELECT TO RECEIVE THESE SERVICES	ALL BUT VERY LIMITED COINSURANCE FOR OUTPATIENT DRUGS AND INPATIENT RESPITE CARE	$0	BALANCE

PLAN B

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

*ONCE YOU HAVE BEEN BILLED $100 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 $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80% (GENERALLY)	20% (GENERALLY)	$0
PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)	$0	$0	ALL COSTS
BLOOD			
FIRST 3 PINTS	$0	ALL COSTS	$0
NEXT $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(CONTINUED)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--MEDICALLY NECESSARY SKILLED CARE SERVICES AND MEDICAL SUPPLIES	100%	$0	$0
--DURABLE MEDICAL EQUIPMENT			
FIRST $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0

PLAN C

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

*A BENEFIT PERIOD BEGINS ON THE FIRST DAY YOU RECEIVE SERVICE AS AN INPATIENT IN A HOSPITAL AND ENDS AFTER YOU HAVE BEEN OUT OF THE HOSPITAL AND HAVE NOT RECEIVED SKILLED CARE IN ANY OTHER FACILITY FOR 60 DAYS IN A ROW.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* SEMIPRIVATE ROOM AND BOARD, GENERAL NURSING AND MISCELLANEOUS SERVICES AND SUPPLIES			
FIRST 60 DAYS	ALL BUT $628	$628 (PART A DEDUCTIBLE)	$0
61ST THRU 90TH DAY	ALL BUT $157 A DAY	$157 A DAY	$0
91ST DAY AND AFTER			
--WHILE USING 60 LIFETIME RESERVE DAYS	ALL BUT $314 A DAY	$314 A DAY	$0
--ONCE LIFETIME RESERVE DAYS ARE USED:			
--ADDITIONAL 365 DAYS	$0	100% OF MEDICARE ELIGIBLE EXPENSES	$0
--BEYOND THE ADDITIONAL 365 DAYS	$0	$0	ALL COSTS
SKILLED NURSING FACILITY CARE* YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING HAVING BEEN IN A HOSPITAL FOR AT LEAST 3 DAYS AND ENTERED A MEDICARE-APPROVED FACILITY WITHIN 30 DAYS AFTER LEAVING THE HOSPITAL			
FIRST 20 DAYS	ALL APPROVED AMOUNTS	$0	$0
21ST THRU 100TH DAY	ALL BUT $78.50 A DAY	UP TO $78.50 A DAY	$0
101ST DAY AND AFTER	$0	$0	ALL COSTS

BLOOD FIRST 3 PINTS ADDITIONAL AMOUNTS	 $0 100%	 3 PINTS $0	 $0 $0
HOSPICE CARE AVAILABLE AS LONG AS YOUR DOCTOR CERTIFIES YOU ARE TERMINALLY ILL AND YOU ELECT TO RECEIVE THESE SERVICES	ALL BUT VERY LIMITED COINSURANCE FOR OUTPATIENT DRUGS AND INPATIENT RESPITE CARE	$0	BALANCE

PLAN C

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

*ONCE YOU HAVE BEEN BILLED $100 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 $100 OF MEDICARE APPROVED AMOUNTS*	$0	$100 (PART B DEDUCTIBLE)	$0
REMAINDER OF MEDICARE APPROVED AMOUNTS	80% (GENERALLY)	20% (GENERALLY)	$0
PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)	$0	$0	ALL COSTS
BLOOD FIRST 3 PINTS	$0	ALL COSTS	$0
NEXT $100 OF MEDICARE APPROVED AMOUNTS*	$0	$100 (PART B DEDUCTIBLE)	$0
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(CONTINUED)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--MEDICALLY NECESSARY SKILLED CARE SERVICES AND MEDICAL SUPPLIES	100%	$0	$0
--DURABLE MEDICAL EQUIPMENT			
FIRST $100 OF MEDICARE APPROVED AMOUNTS*	$0	$100 (PART B DEDUCTIBLE)	$0
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

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

PLAN D

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

*A BENEFIT PERIOD BEGINS ON THE FIRST DAY YOU RECEIVE SERVICE AS AN INPATIENT IN A HOSPITAL AND ENDS AFTER YOU HAVE BEEN OUT OF THE HOSPITAL AND HAVE NOT RECEIVED SKILLED CARE IN ANY OTHER FACILITY FOR 60 DAYS IN A ROW.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* SEMIPRIVATE ROOM AND BOARD, GENERAL NURSING AND MISCELLANEOUS SERVICES AND SUPPLIES			
FIRST 60 DAYS	ALL BUT $628	$628 (PART A DEDUCTIBLE)	$0
61ST THRU 90TH DAY	ALL BUT $157 A DAY	$157 A DAY	$0
91ST DAY AND AFTER			
--WHILE USING 60 LIFETIME RESERVE DAYS	ALL BUT $314 A DAY	$314 A DAY	$0
--ONCE LIFETIME RESERVE DAYS ARE USED:			
--ADDITIONAL 365 DAYS	$0	100% OF MEDICARE ELIGIBLE EXPENSES	$0
--BEYOND THE ADDITIONAL 365 DAYS	$0	$0	ALL COSTS
SKILLED NURSING FACILITY CARE* YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING HAVING BEEN IN A HOSPITAL FOR AT LEAST 3 DAYS AND ENTERED A MEDICARE-APPROVED FACILITY WITHIN 30 DAYS AFTER LEAVING THE HOSPITAL			
FIRST 20 DAYS	ALL APPROVED AMOUNTS	$0	$0
21ST THRU 100TH DAY	ALL BUT $78.50 A DAY	UP TO $78.50 A DAY	$0
101ST DAY AND AFTER	$0	$0	ALL COSTS

BLOOD FIRST 3 PINTS ADDITIONAL AMOUNTS	 $0 100%	 3 PINTS $0	 $0 $0
HOSPICE CARE AVAILABLE AS LONG AS YOUR DOCTOR CERTIFIES YOU ARE TERMINALLY ILL AND YOU ELECT TO RECEIVE THESE SERVICES	ALL BUT VERY LIMITED COINSURANCE FOR OUTPATIENT DRUGS AND INPATIENT RESPITE CARE	$0	BALANCE

PLAN D

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

*ONCE YOU HAVE BEEN BILLED $100 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 $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80% (GENERALLY)	20% (GENERALLY)	$0
PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)	$0	$0	ALL COSTS
BLOOD FIRST 3 PINTS	$0	ALL COSTS	$0
NEXT $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(CONTINUED)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--MEDICALLY NECESSARY SKILLED CARE SERVICES AND MEDICAL SUPPLIES	100%	$0	$0
--DURABLE MEDICAL EQUIPMENT			
FIRST $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0
AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE			
HOME CARE CERTIFIED BY YOUR DOCTOR, FOR PERSONAL CARE DURING RECOVERY FROM AN INJURY OR SICKNESS FOR WHICH MEDICARE APPROVED A HOME CARE TREATMENT PLAN			
--BENEFIT FOR EACH VISIT	$0	ACTUAL CHARGES TO $40 A VISIT	BALANCE
--NUMBER OF VISITS COVERED (MUST BE RECEIVED WITHIN 8 WEEKS OF LAST MEDICARE APPROVED VISIT)	$0	UP TO THE NUMBER OF MEDICARE APPROVED VISITS, NOT TO EXCEED 7 EACH WEEK	
--CALENDAR YEAR MAXIMUM	$0	$1,600	

(CONTINUED)

OTHER BENEFITS--NOT COVERED BY MEDICARE

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

PLAN E

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 $628	$628 (PART A DEDUCTIBLE)	$0
61ST THRU 90TH DAY	ALL BUT $157 A DAY	$157 A DAY	$0
91ST DAY AND AFTER			
--WHILE USING 60 LIFETIME RESERVE DAYS	ALL BUT $314 A DAY	$314 A DAY	$0
--ONCE LIFETIME RESERVE DAYS ARE USED:			
--ADDITIONAL 365 DAYS	$0	100% OF MEDICARE ELIGIBLE EXPENSES	$0
--BEYOND THE ADDITIONAL 365 DAYS	$0	$0	ALL COSTS
SKILLED NURSING FACILITY CARE* YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING HAVING BEEN IN A HOSPITAL FOR AT LEAST 3 DAYS AND ENTERED A MEDICARE-APPROVED FACILITY WITHIN 30 DAYS AFTER LEAVING THE HOSPITAL			
FIRST 20 DAYS	ALL APPROVED AMOUNTS	$0	$0
21ST THRU 100TH DAY	ALL BUT $78.50 A DAY	UP TO $78.50 A DAY	$0
101ST DAY AND AFTER	$0	$0	ALL COSTS

BLOOD FIRST 3 PINTS ADDITIONAL AMOUNTS	 $0 100%	 3 PINTS $0	 $0 $0
HOSPICE CARE AVAILABLE AS LONG AS YOUR DOCTOR CERTIFIES YOU ARE TERMINALLY ILL AND YOU ELECT TO RECEIVE THESE SERVICES	ALL BUT VERY LIMITED COINSURANCE FOR OUTPATIENT DRUGS AND INPATIENT RESPITE CARE	$0	BALANCE

PLAN E

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

*ONCE YOU HAVE BEEN BILLED $100 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 $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80% (GENERALLY)	20% (GENERALLY)	$0
PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)	$0	$0	ALL COSTS
BLOOD FIRST 3 PINTS	$0	ALL COSTS	$0
NEXT $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(CONTINUED)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--MEDICALLY NECESSARY SKILLED CARE SERVICES AND MEDICAL SUPPLIES	100%	$0	$0
--DURABLE MEDICAL EQUIPMENT			
FIRST $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL-- NOT COVERED BY MEDICARE MEDICALLY NECESSARY EMERGENCY CARE SERVICES BEGINNING DURING THE FIRST 60 DAYS OF EACH TRIP OUTSIDE THE USA			
FIRST $250 EACH CALENDAR YEAR	$0	$0	$250
REMAINDER OF CHARGES	$0	80% TO A LIFETIME MAXIMUM BENEFIT OF $50,000	20% AND AMOUNTS OVER THE $50,000 LIFETIME MAXIMUM
PREVENTIVE MEDICAL CARE BENEFIT--NOT COVERED BY MEDICARE ANNUAL PHYSICAL AND PREVENTIVE TESTS AND SERVICES SUCH AS: FECAL OCCULT BLOOD TEST, DIGITAL RECTAL EXAM, MAMMOGRAM, HEARING SCREENING, DIPSTICK URINALYSIS, DIABETES SCREENING, THYROID FUNCTION TEST, INFLUENZA SHOT, TETANUS AND DIPHTHERIA BOOSTER AND EDUCATION,			

ADMINISTERED OR ORDERED BY YOUR DOCTOR WHEN NOT COVERED BY MEDICARE			
FIRST $120 EACH CALENDAR YEAR	$0	$120	$0
ADDITIONAL CHARGES	$0	$0	ALL COSTS

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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* SEMIPRIVATE ROOM AND BOARD, GENERAL NURSING AND MISCELLANEOUS SERVICES AND SUPPLIES			
FIRST 60 DAYS	ALL BUT $628	$628 (PART A DEDUCTIBLE)	$0
61ST THRU 90TH DAY	ALL BUT $157 A DAY	$157 A DAY	$0
91ST DAY AND AFTER --WHILE USING 60 LIFETIME RESERVE DAYS	ALL BUT $314 A DAY	$314 A DAY	$0
--ONCE LIFETIME RESERVE DAYS ARE USED: --ADDITIONAL 365 DAYS	$0	100% OF MEDICARE ELIGIBLE EXPENSES	$0
--BEYOND THE ADDITIONAL 365 DAYS	$0	$0	ALL COSTS
SKILLED NURSING FACILITY CARE* YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING HAVING BEEN IN A HOSPITAL FOR AT LEAST 3 DAYS AND ENTERED A MEDICARE-APPROVED FACILITY WITHIN 30 DAYS AFTER LEAVING THE HOSPITAL			
FIRST 20 DAYS	ALL APPROVED AMOUNTS	$0	$0
21ST THRU 100TH DAY	ALL BUT $78.50 A DAY	UP TO $78.50 A DAY	$0
101ST DAY AND AFTER	$0	$0	ALL COSTS

BLOOD FIRST 3 PINTS ADDITIONAL AMOUNTS	 $0 100%	 3 PINTS $0	 $0 $0
HOSPICE CARE AVAILABLE AS LONG AS YOUR DOCTOR CERTIFIES YOU ARE TERMINALLY ILL AND YOU ELECT TO RECEIVE THESE SERVICES	ALL BUT VERY LIMITED COINSURANCE FOR OUTPATIENT DRUGS AND INPATIENT RESPITE CARE	$0	BALANCE

PLAN F

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

*ONCE YOU HAVE BEEN BILLED $100 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 PHYSI- CIAN'S SERVICES, INPATIENT AND OUTPATIENT MEDICAL AND SURGICAL SERVICES AND SUP- PLIES, PHYSICAL AND SPEECH THERAPY, DIAGNOSTIC TESTS, DURABLE MEDICAL EQUIPMENT,			
FIRST $100 OF MEDICARE APPROVED AMOUNTS*	$0	$100 (PART B DEDUCTIBLE)	$0
REMAINDER OF MEDICARE APPROVED AMOUNTS	80% (GENERALLY)	20% (GENERALLY)	$0
PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)	$0	100%	$0
BLOOD FIRST 3 PINTS	$0	ALL COSTS	$0
NEXT $100 OF MEDICARE APPROVED AMOUNTS*	$0	$100 (PART B DEDUCTIBLE)	$0
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(CONTINUED)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--MEDICALLY NECESSARY SKILLED CARE SERVICES AND MEDICAL SUPPLIES	100%	$0	$0
--DURABLE MEDICAL EQUIPMENT			
FIRST $100 OF MEDICARE APPROVED AMOUNTS*	$0	$100 (PART B DEDUCTIBLE)	$0
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

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

PLAN G

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 $628	$628 (PART A DEDUCTIBLE)	$0
61ST THRU 90TH DAY	ALL BUT $157 A DAY	$157 A DAY	$0
91ST DAY AND AFTER			
--WHILE USING 60 LIFETIME RESERVE DAYS	ALL BUT $314 A DAY	$314 A DAY	$0
--ONCE LIFETIME RESERVE DAYS ARE USED:			
--ADDITIONAL 365 DAYS	$0	100% OF MEDICARE ELIGIBLE EXPENSES	$0
--BEYOND THE ADDITIONAL 365 DAYS	$0	$0	ALL COSTS
SKILLED NURSING FACILITY CARE* YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING HAVING BEEN IN A HOSPITAL FOR AT LEAST 3 DAYS AND ENTERED A MEDICARE-APPROVED FACILITY WITHIN 30 DAYS AFTER LEAVING THE HOSPITAL			
FIRST 20 DAYS	ALL APPROVED AMOUNTS	$0	$0
21ST THRU 100TH DAY	ALL BUT $78.50 A DAY	UP TO $78.50 A DAY	$0
101ST DAY AND AFTER	$0	$0	ALL COSTS

BLOOD FIRST 3 PINTS ADDITIONAL AMOUNTS	 $0 100%	 3 PINTS $0	 $0 $0
HOSPICE CARE AVAILABLE AS LONG AS YOUR DOCTOR CERTIFIES YOU ARE TERMINALLY ILL AND YOU ELECT TO RECEIVE THESE SERVICES	ALL BUT VERY LIMITED COINSURANCE FOR OUTPATIENT DRUGS AND INPATIENT RESPITE CARE	$0	BALANCE

PLAN G

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

*ONCE YOU HAVE BEEN BILLED $100 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 PHYSI- CIAN'S SERVICES, INPATIENT AND OUTPATIENT MEDICAL AND SURGICAL SERVICES AND SUP- PLIES, PHYSICAL AND SPEECH THERAPY, DIAGNOSTIC TESTS, DURABLE MEDICAL EQUIPMENT,			
FIRST $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80% (GENERALLY)	20% (GENERALLY)	$0
PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)	$0	80%	20%
BLOOD FIRST 3 PINTS	$0	ALL COSTS	$0
NEXT $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(CONTINUED)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--MEDICALLY NECESSARY SKILLED CARE SERVICES AND MEDICAL SUPPLIES	100%	$0	$0
--DURABLE MEDICAL EQUIPMENT			
FIRST $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0
AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE			
HOME CARE CERTIFIED BY YOUR DOCTOR, FOR PERSONAL CARE DURING RECOVERY FROM AN INJURY OR SICKNESS FOR WHICH MEDICARE APPROVED A HOME CARE TREATMENT PLAN			
--BENEFIT FOR EACH VISIT	$0	ACTUAL CHARGES TO $40 A VISIT	BALANCE
--NUMBER OF VISITS COVERED (MUST BE RECEIVED WITHIN 8 WEEKS OF LAST MEDICARE APPROVED VISIT)	$0	UP TO THE NUMBER OF MEDICARE APPROVED VISITS, NOT TO EXCEED 7 EACH WEEK	
--CALENDAR YEAR MAXIMUM	$0	$1,600	

(CONTINUED)

OTHER BENEFITS--NOT COVERED BY MEDICARE

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

PLAN H

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 $628	$628 (PART A DEDUCTIBLE)	$0
61ST THRU 90TH DAY	ALL BUT $157 A DAY	$157 A DAY	$0
91ST DAY AND AFTER			
--WHILE USING 60 LIFETIME RESERVE DAYS	ALL BUT $314 A DAY	$314 A DAY	$0
--ONCE LIFETIME RESERVE DAYS ARE USED:			
--ADDITIONAL 365 DAYS	$0	100% OF MEDICARE ELIGIBLE EXPENSES	$0
--BEYOND THE ADDITIONAL 365 DAYS	$0	$0	ALL COSTS
SKILLED NURSING FACILITY CARE* YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING HAVING BEEN IN A HOSPITAL FOR AT LEAST 3 DAYS AND ENTERED A MEDICARE-APPROVED FACILITY WITHIN 30 DAYS AFTER LEAVING THE HOSPITAL			
FIRST 20 DAYS	ALL APPROVED AMOUNTS	$0	$0
21ST THRU 100TH DAY	ALL BUT $78.50 A DAY	UP TO $78.50 A DAY	$0
101ST DAY AND AFTER	$0	$0	ALL COSTS

BLOOD			
FIRST 3 PINTS	$0	3 PINTS	$0
ADDITIONAL AMOUNTS	100%	$0	$0
HOSPICE CARE AVAILABLE AS LONG AS YOUR DOCTOR CERTIFIES YOU ARE TERMINALLY ILL AND YOU ELECT TO RECEIVE THESE SERVICES	ALL BUT VERY LIMITED COINSURANCE FOR OUTPATIENT DRUGS AND INPATIENT RESPITE CARE	$0	BALANCE

PLAN H

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

*ONCE YOU HAVE BEEN BILLED $100 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 PHYSI- CIAN'S SERVICES, INPATIENT AND OUTPATIENT MEDICAL AND SURGICAL SERVICES AND SUP- PLIES, PHYSICAL AND SPEECH THERAPY, DIAGNOSTIC TESTS, DURABLE MEDICAL EQUIPMENT,			
FIRST $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80% (GENERALLY)	20% (GENERALLY)	$0
PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)	$0	$0	ALL COSTS
BLOOD FIRST 3 PINTS	$0	ALL COSTS	$0
NEXT $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(CONTINUED)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--MEDICALLY NECESSARY SKILLED CARE SERVICES AND MEDICAL SUPPLIES	100%	$0	$0
--DURABLE MEDICAL EQUIPMENT			
FIRST $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE MEDICALLY NECESSARY EMERGENCY CARE SERVICES BEGINNING DURING THE FIRST 60 DAYS OF EACH TRIP OUTSIDE THE USA			
FIRST $250 EACH CALENDAR YEAR	$0	$0	$250
REMAINDER OF CHARGES	$0	80% TO A LIFETIME MAXIMUM BENEFIT OF $50,000	20% AND AMOUNTS OVER THE $50,000 LIFETIME MAXIMUM
BASIC OUTPATIENT PRESCRIPTION DRUGS--NOT COVERED BY MEDICARE			
FIRST $250 EACH CALENDAR YEAR	$0	$0	$250
NEXT $2,500 EACH CALENDAR YEAR	$0	50%--$1,250 CALENDAR YEAR MAXIMUM BENEFIT	50%
OVER $2,500 EACH CALENDAR YEAR	$0	$0	ALL COSTS

PLAN I

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 $628	$628 (PART A DEDUCTIBLE)	$0
61ST THRU 90TH DAY	ALL BUT $157 A DAY	$157 A DAY	$0
91ST DAY AND AFTER			
--WHILE USING 60 LIFETIME RESERVE DAYS	ALL BUT $314 A DAY	$314 A DAY	$0
--ONCE LIFETIME RESERVE DAYS ARE USED:			
--ADDITIONAL 365 DAYS	$0	100% OF MEDICARE ELIGIBLE EXPENSES	$0
--BEYOND THE ADDITIONAL 365 DAYS	$0	$0	ALL COSTS
SKILLED NURSING FACILITY CARE* YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING HAVING BEEN IN A HOSPITAL FOR AT LEAST 3 DAYS AND ENTERED A MEDICARE-APPROVED FACILITY WITHIN 30 DAYS AFTER LEAVING THE HOSPITAL			
FIRST 20 DAYS	ALL APPROVED AMOUNTS	$0	$0
21ST THRU 100TH DAY	ALL BUT $78.50 A DAY	UP TO $78.50 A DAY	$0
101ST DAY AND AFTER	$0	$0	ALL COSTS

BLOOD FIRST 3 PINTS ADDITIONAL AMOUNTS	 $0 100%	 3 PINTS $0	 $0 $0
HOSPICE CARE AVAILABLE AS LONG AS YOUR DOCTOR CERTIFIES YOU ARE TERMINALLY ILL AND YOU ELECT TO RECEIVE THESE SERVICES	ALL BUT VERY LIMITED COINSURANCE FOR OUTPATIENT DRUGS AND INPATIENT RESPITE CARE	$0	BALANCE

PLAN I

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

*ONCE YOU HAVE BEEN BILLED $100 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 PHYSI- CIAN'S SERVICES, INPATIENT AND OUTPATIENT MEDICAL AND SURGICAL SERVICES AND SUP- PLIES, PHYSICAL AND SPEECH THERAPY, DIAGNOSTIC TESTS, DURABLE MEDICAL EQUIPMENT,			
FIRST $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80% (GENERALLY)	20% (GENERALLY)	$0
PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)	$0	100%	$0
BLOOD FIRST 3 PINTS	$0	ALL COSTS	$0
NEXT $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(CONTINUED)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--MEDICALLY NECESSARY SKILLED CARE SERVICES AND MEDICAL SUPPLIES	100%	$0	$0
--DURABLE MEDICAL EQUIPMENT			
FIRST $100 OF MEDICARE APPROVED AMOUNTS*	$0	$0	$100 (PART B DEDUCTIBLE)
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0
AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE			
HOME CARE CERTIFIED BY YOUR DOCTOR, FOR PERSONAL CARE DURING RECOVERY FROM AN INJURY OR SICKNESS FOR WHICH MEDICARE APPROVED A HOME CARE TREATMENT PLAN			BALANCE
--BENEFIT FOR EACH VISIT	$0	ACTUAL CHARGES TO $40 A VISIT	
--NUMBER OF VISITS COVERED (MUST BE RECEIVED *WITHIN 8 WEEKS OF* LAST MEDICARE APPROVED VISIT)	$0	UP TO THE NUMBER OF MEDICARE APPROVED VISITS, NOT TO EXCEED 7 EACH WEEK	
--CALENDAR YEAR MAXIMUM	$0	$1,600	

(CONTINUED)

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE MEDICALLY NECESSARY EMERGENCY CARE SERVICES BEGINNING DURING THE FIRST 60 DAYS OF EACH TRIP OUTSIDE THE USA			
FIRST $250 EACH CALENDAR YEAR	$0	$0	$250
REMAINDER OF CHARGES*	$0	80% TO A LIFETIME MAXIMUM BENEFIT OF $50,000	20% AND AMOUNTS OVER THE $50,000 LIFETIME MAXIMUM
BASIC OUTPATIENT PRESCRIPTION DRUGS--NOT COVERED BY MEDICARE			
FIRST $250 EACH CALENDAR YEAR	$0	$0	$250
NEXT $2,500 EACH CALENDAR YEAR	$0	50%--$1,250 CALENDAR YEAR MAXIMUM BENEFIT	50%
OVER $2,500 EACH CALENDAR YEAR	$0	$0	ALL COSTS

PLAN J

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 $628	$628 (PART A DEDUCTIBLE)	$0
61ST THRU 90TH DAY	ALL BUT $157 A DAY	$157 A DAY	$0
91ST DAY AND AFTER			
--WHILE USING 60 LIFETIME RESERVE DAYS	ALL BUT $314 A DAY	$314 A DAY	$0
--ONCE LIFETIME RESERVE DAYS ARE USED:			
--ADDITIONAL 365 DAYS	$0	100% OF MEDICARE ELIGIBLE EXPENSES	$0
--BEYOND THE ADDITIONAL 365 DAYS	$0	$0	ALL COSTS
SKILLED NURSING FACILITY CARE* YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING HAVING BEEN IN A HOSPITAL FOR AT LEAST 3 DAYS AND ENTERED A MEDICARE-APPROVED FACILITY WITHIN 30 DAYS AFTER LEAVING THE HOSPITAL			
FIRST 20 DAYS	ALL APPROVED AMOUNTS	$0	$0
21ST THRU 100TH DAY	ALL BUT $78.50 A DAY	UP TO $78.50 A DAY	$0
101ST DAY AND AFTER	$0	$0	ALL COSTS

BLOOD			
FIRST 3 PINTS	$0	3 PINTS	$0
ADDITIONAL AMOUNTS	100%	$0	$0
HOSPICE CARE AVAILABLE AS LONG AS YOUR DOCTOR CERTIFIES YOU ARE TERMINALLY ILL AND YOU ELECT TO RECEIVE THESE SERVICES	ALL BUT VERY LIMITED COINSURANCE FOR OUTPATIENT DRUGS AND INPATIENT RESPITE CARE	$0	BALANCE

PLAN J

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

*ONCE YOU HAVE BEEN BILLED $100 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 $100 OF MEDICARE APPROVED AMOUNTS*	$0	$100 (PART B DEDUCTIBLE)	$0
REMAINDER OF MEDICARE APPROVED AMOUNTS	80% (GENERALLY)	20% (GENERALLY)	$0
PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)	$0	100%	$0
BLOOD			
FIRST 3 PINTS	$0	ALL COSTS	$0
NEXT $100 OF MEDICARE APPROVED AMOUNTS*	$0	$100 (PART B DEDUCTIBLE)	$0
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(CONTINUED)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--MEDICALLY NECESSARY SKILLED CARE SERVICES AND MEDICAL SUPPLIES	100%	$0	$0
--DURABLE MEDICAL EQUIPMENT			
FIRST $100 OF MEDICARE APPROVED AMOUNTS*	$0	$100 (PART B DEDUCTIBLE)	$0
REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	$0
AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE HOME CARE CERTIFIED BY YOUR DOCTOR, FOR PERSONAL CARE BEGINNING DURING RECOVERY FROM AN INJURY OR SICKNESS FOR WHICH MEDICARE APPROVED A HOME CARE TREATMENT PLAN			
--BENEFIT FOR EACH VISIT	$0	ACTUAL CHARGES TO $40 A VISIT	BALANCE
--NUMBER OF VISITS COVERED (MUST BE RECEIVED WITHIN 8 WEEKS OF LAST MEDICARE APPROVED VISIT)	$0	UP TO THE NUMBER OF MEDICARE APPROVED VISITS, NOT TO EXCEED 7 EACH WEEK	
--CALENDAR YEAR MAXIMUM	$0	$1,600	

(CONTINUED)

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE MEDICALLY NECESSARY EMERGENCY CARE SERVICES BEGINNING DURING THE FIRST 60 DAYS OF EACH TRIP OUTSIDE THE USA			
FIRST $250 EACH CALENDAR YEAR	$0	$0	$250
REMAINDER OF CHARGES	$0	80% TO A LIFETIME MAXIMUM BENEFIT OF $50,000	20% AND AMOUNTS OVER THE $50,000 LIFETIME MAXIMUM
EXTENDED OUTPATIENT PRESCRIPTION DRUGS--NOT COVERED BY MEDICARE			
FIRST $250 EACH CALENDAR YEAR	$0	$0	$250
NEXT $6,000 EACH CALENDAR YEAR	$0	50%--$3,000 CALENDAR YEAR MAXIMUM BENEFIT	50%
OVER $6,000 EACH CALENDAR YEAR	$0	$0	ALL COSTS
PREVENTIVE MEDICAL CARE BENEFIT--NOT COVERED BY MEDICARE ANNUAL PHYSICAL AND PREVENTIVE TESTS AND SERVICES SUCH AS: FECAL OCCULT BLOOD TEST, DIGITAL RECTAL EXAM, MAMMOGRAM, HEARING SCREENING, DIPSTICK URINALYSIS, DIABETES SCREENING, THYROID FUNCTION TEST, INFLUENZA SHOT, TETANUS AND DIPHTHERIA BOOSTER AND EDUCATION, ADMINISTERED OR ORDERED BY YOUR DOCTOR WHEN NOT COVERED BY MEDICARE			
FIRST $120 EACH CALENDAR YEAR	$0	$120	$0
ADDITIONAL CHARGES	$0	$0	ALL COSTS

SEC. 467. (1) THIS SECTION APPLIES TO MEDICARE SELECT CERTIFICATES.

(2) AS USED IN THIS SECTION:

(A) "COMPLAINT" MEANS ANY DISSATISFACTION EXPRESSED BY AN INDIVIDUAL CONCERNING A MEDICARE SELECT HEALTH CARE CORPORATION OR ITS NETWORK PROVIDERS.

(B) "GRIEVANCE" MEANS A DISSATISFACTION EXPRESSED IN WRITING BY AN INDIVIDUAL COVERED UNDER A MEDICARE SELECT CERTIFICATE WITH THE ADMINISTRATION, CLAIMS PRACTICES, OR PROVISION OF SERVICES CONCERNING A MEDICARE SELECT HEALTH CARE CORPORATION OR ITS NETWORK PROVIDERS.

(C) "MEDICARE SELECT HEALTH CARE CORPORATION" MEANS A HEALTH CARE CORPORATION OFFERING, OR SEEKING TO OFFER, A MEDICARE SELECT CERTIFICATE.

(D) "MEDICARE SELECT CERTIFICATE" MEANS A MEDICARE SUPPLEMENT CERTIFICATE THAT CONTAINS RESTRICTED NETWORK PROVISIONS.

(E) "NETWORK PROVIDER" MEANS A PROVIDER OF HEALTH CARE, OR A GROUP OF PROVIDERS OF HEALTH CARE, THAT HAS ENTERED INTO A WRITTEN AGREEMENT WITH THE HEALTH CARE CORPORATION TO PROVIDE BENEFITS UNDER A MEDICARE SELECT CERTIFICATE.

(F) "RESTRICTED NETWORK PROVISION" MEANS ANY PROVISION THAT CONDITIONS THE PAYMENT OF BENEFITS, IN WHOLE OR IN PART, ON THE USE OF NETWORK PROVIDERS.

(G) "SERVICE AREA" MEANS THE GEOGRAPHIC AREA APPROVED BY THE COMMISSIONER WITHIN WHICH A HEALTH CARE CORPORATION IS AUTHORIZED TO OFFER A MEDICARE SELECT CERTIFICATE.

(3) A CERTIFICATE SHALL NOT BE ADVERTISED AS A MEDICARE SELECT CERTIFICATE UNLESS IT MEETS THE REQUIREMENTS OF THIS SECTION.

(4) THE COMMISSIONER MAY AUTHORIZE A HEALTH CARE CORPORATION TO OFFER A MEDICARE SELECT CERTIFICATE, PURSUANT TO THIS SECTION AND SECTION 1882 OF PART C OF TITLE XVIII OF THE SOCIAL SECURITY ACT, CHAPTER 531, 49 STAT. 620, 42 U.S.C. 1395ss, IF THE COMMISSIONER FINDS THAT THE HEALTH CARE CORPORATION HAS SATISFIED ALL NECESSARY REQUIREMENTS.

(5) A MEDICARE SELECT HEALTH CARE CORPORATION SHALL NOT ISSUE A MEDICARE SELECT CERTIFICATE IN THIS STATE UNTIL ITS PLAN OF OPERATION HAS BEEN APPROVED BY THE COMMISSIONER.

(6) A MEDICARE SELECT HEALTH CARE CORPORATION SHALL FILE A PROPOSED PLAN OF OPERATION WITH THE COMMISSIONER IN A FORMAT PRESCRIBED BY THE COMMISSIONER. THE PLAN OF OPERATION SHALL CONTAIN AT LEAST THE FOLLOWING INFORMATION:

(A) EVIDENCE THAT ALL COVERED SERVICES THAT ARE SUBJECT TO RESTRICTED NETWORK PROVISIONS ARE AVAILABLE AND ACCESSIBLE THROUGH NETWORK PROVIDERS, AS FOLLOWS:

(*i*) THAT SERVICES CAN BE PROVIDED BY NETWORK PROVIDERS WITH REASONABLE PROMPTNESS WITH RESPECT TO GEOGRAPHIC LOCATION, HOURS OF OPERATION, AND AFTER-HOUR CARE. THE HOURS OF OPERATION AND AVAILABILITY OF AFTER-HOUR CARE SHALL REFLECT USUAL PRACTICE IN THE LOCAL AREA. GEOGRAPHIC AVAILABILITY SHALL REFLECT THE USUAL TRAVEL TIMES WITHIN THE COMMUNITY.

(*ii*) THAT THE NUMBER OF NETWORK PROVIDERS IN THE SERVICE AREA IS SUFFICIENT, WITH RESPECT TO CURRENT AND EXPECTED

CERTIFICATE HOLDERS, EITHER TO DELIVER ADEQUATELY ALL SERVICES THAT ARE SUBJECT TO A RESTRICTED NETWORK PROVISION OR TO MAKE APPROPRIATE REFERRALS.

(*iii*) THAT THERE ARE WRITTEN AGREEMENTS WITH NETWORK PROVIDERS DESCRIBING SPECIFIC RESPONSIBILITIES.

(*iv*) THAT EMERGENCY CARE IS AVAILABLE 24 HOURS PER DAY AND 7 DAYS PER WEEK.

(*v*) THAT IN THE CASE OF COVERED SERVICES THAT ARE SUBJECT TO A RESTRICTED NETWORK PROVISION AND ARE PROVIDED ON A PREPAID BASIS, THERE ARE WRITTEN AGREEMENTS WITH NETWORK PROVIDERS PROHIBITING SUCH PROVIDERS FROM BILLING OR OTHERWISE SEEKING REIMBURSEMENT FROM OR RECOURSE AGAINST ANY INDIVIDUAL COVERED UNDER A MEDICARE SELECT CERTIFICATE. THIS SUBPARAGRAPH DOES NOT APPLY TO SUPPLEMENTAL CHARGES OR COINSURANCE AMOUNTS AS STATED IN THE MEDICARE SELECT CERTIFICATE.

(B) A STATEMENT OR MAP PROVIDING A CLEAR DESCRIPTION OF THE SERVICE AREA.

(C) A DESCRIPTION OF THE GRIEVANCE PROCEDURE TO BE USED.

(D) A DESCRIPTION OF THE QUALITY ASSURANCE PROGRAM, INCLUDING ALL OF THE FOLLOWING:

(*i*) THE FORMAL ORGANIZATIONAL STRUCTURE.

(*ii*) THE WRITTEN CRITERIA FOR SELECTION, RETENTION, AND REMOVAL OF NETWORK PROVIDERS.

(*iii*) THE PROCEDURES FOR EVALUATING QUALITY OF CARE PROVIDED BY NETWORK PROVIDERS AND THE PROCESS TO INITIATE CORRECTIVE ACTION IF WARRANTED.

(E) A LIST AND DESCRIPTION, BY SPECIALTY, OF THE NETWORK PROVIDERS.

(F) COPIES OF THE WRITTEN INFORMATION PROPOSED TO BE USED BY THE HEALTH CARE CORPORATION TO COMPLY WITH SUBSECTION (10).

(G) ANY OTHER INFORMATION REQUESTED BY THE COMMISSIONER.

(7) A MEDICARE SELECT HEALTH CARE CORPORATION SHALL FILE ANY PROPOSED CHANGES TO THE PLAN OF OPERATION, EXCEPT FOR CHANGES TO THE LIST OF NETWORK PROVIDERS, WITH THE COMMISSIONER PRIOR TO IMPLEMENTING ANY CHANGES. AN UPDATED LIST OF NETWORK PROVIDERS SHALL BE FILED WITH THE COMMISSIONER AT LEAST QUARTERLY. CHANGES SHALL BE CONSIDERED APPROVED BY THE COMMISSIONER AFTER 30 DAYS UNLESS SPECIFICALLY DISAPPROVED.

(8) A MEDICARE SELECT CERTIFICATE SHALL NOT RESTRICT PAYMENT FOR COVERED SERVICES PROVIDED BY NONNETWORK PROVIDERS IF THE SERVICES ARE FOR SYMPTOMS REQUIRING EMERGENCY CARE OR ARE IMMEDIATELY REQUIRED FOR AN UNFORESEEN ILLNESS, INJURY, OR A CONDITION AND IT IS NOT REASONABLE TO OBTAIN SUCH SERVICES THROUGH A NETWORK PROVIDER.

(9) A MEDICARE SELECT CERTIFICATE SHALL PROVIDE PAYMENT FOR FULL COVERAGE UNDER THE CERTIFICATE FOR COVERED SERVICES THAT ARE NOT AVAILABLE THROUGH NETWORK PROVIDERS.

(10) A MEDICARE SELECT HEALTH CARE CORPORATION SHALL MAKE FULL AND FAIR DISCLOSURE IN WRITING OF THE PROVISIONS, RESTRICTIONS, AND LIMITATIONS OF THE MEDICARE SELECT CERTIFICATE TO EACH APPLICANT. THIS DISCLOSURE SHALL INCLUDE AT LEAST ALL OF THE FOLLOWING:

(A) AN OUTLINE OF COVERAGE SUFFICIENT TO PERMIT THE APPLICANT TO COMPARE THE COVERAGE AND PREMIUMS OF THE MEDICARE SELECT CERTIFICATE WITH OTHER MEDICARE SUPPLEMENT CERTIFICATES OFFERED BY THE HEALTH CARE CORPORATION OR OFFERED BY OTHER HEALTH CARE CORPORATIONS.

(B) A DESCRIPTION, INCLUDING ADDRESS, PHONE NUMBER, AND HOURS OF OPERATION, OF THE NETWORK PROVIDERS, INCLUDING PRIMARY CARE PHYSICIANS, SPECIALTY PHYSICIANS, HOSPITALS, AND OTHER PROVIDERS.

(C) A DESCRIPTION OF THE RESTRICTED NETWORK PROVISIONS, INCLUDING PAYMENTS FOR COINSURANCE AND DEDUCTIBLES IF PROVIDERS OTHER THAN NETWORK PROVIDERS ARE UTILIZED.

(D) A DESCRIPTION OF COVERAGE FOR EMERGENCY AND URGENTLY NEEDED CARE AND OTHER OUT-OF-SERVICE AREA COVERAGE.

(E) A DESCRIPTION OF LIMITATIONS ON REFERRALS TO RESTRICTED NETWORK PROVIDERS AND TO OTHER PROVIDERS.

(F) A DESCRIPTION OF THE CERTIFICATE HOLDER'S RIGHTS TO PURCHASE ANY OTHER MEDICARE SUPPLEMENT CERTIFICATE OTHERWISE OFFERED BY THE HEALTH CARE CORPORATION.

(G) A DESCRIPTION OF THE MEDICARE SELECT HEALTH CARE CORPORATION'S QUALITY ASSURANCE PROGRAM AND GRIEVANCE PROCEDURE.

(11) PRIOR TO THE SALE OF A MEDICARE SELECT CERTIFICATE, A MEDICARE SELECT HEALTH CARE CORPORATION SHALL OBTAIN FROM THE APPLICANT A SIGNED AND DATED FORM STATING THAT THE APPLICANT HAS RECEIVED THE INFORMATION PROVIDED PURSUANT TO SUBSECTION (10) AND THAT THE APPLICANT UNDERSTANDS THE RESTRICTIONS OF THE MEDICARE SELECT CERTIFICATE.

(12) A MEDICARE SELECT HEALTH CARE CORPORATION SHALL HAVE AND USE PROCEDURES FOR HEARING COMPLAINTS AND RESOLVING WRITTEN GRIEVANCES FROM SUBSCRIBERS. THE PROCEDURES SHALL BE AIMED AT MUTUAL AGREEMENT FOR SETTLEMENT AND MAY INCLUDE ARBITRATION PROCEDURES. THE GRIEVANCE PROCEDURE SHALL BE DESCRIBED IN THE CERTIFICATE AND IN THE OUTLINE OF COVERAGE. AT THE TIME THE CERTIFICATE IS ISSUED, THE HEALTH CARE CORPORATION SHALL PROVIDE DETAILED INFORMATION TO THE CERTIFICATE HOLDER DESCRIBING HOW A GRIEVANCE MAY BE REGISTERED WITH THE HEALTH CARE CORPORATION. GRIEVANCES SHALL BE CONSIDERED IN A TIMELY MANNER AND SHALL BE TRANSMITTED TO APPROPRIATE DECISION-MAKERS WHO HAVE AUTHORITY TO FULLY INVESTIGATE THE ISSUE AND TAKE CORRECTIVE ACTION. IF A GRIEVANCE IS FOUND TO BE VALID, CORRECTIVE ACTION SHALL BE TAKEN PROMPTLY. ALL CONCERNED PARTIES SHALL BE NOTIFIED ABOUT THE RESULTS OF A GRIEVANCE. THE HEALTH CARE CORPORATION SHALL REPORT NO LATER THAN EACH MARCH 31 TO THE COMMISSIONER REGARDING ITS GRIEVANCE PROCEDURE. THE REPORT SHALL BE IN A FORMAT PRESCRIBED BY THE COMMISSIONER AND SHALL CONTAIN THE NUMBER OF GRIEVANCES FILED IN THE PAST YEAR AND A SUMMARY OF THE SUBJECT, NATURE, AND RESOLUTION OF THOSE GRIEVANCES.

(13) AT THE TIME OF INITIAL PURCHASE, A MEDICARE SELECT HEALTH CARE CORPORATION SHALL MAKE AVAILABLE TO EACH APPLICANT FOR A MEDICARE SELECT CERTIFICATE THE OPPORTUNITY TO PURCHASE ANY MEDICARE SUPPLEMENT CERTIFICATE OTHERWISE OFFERED BY THE HEALTH CARE CORPORATION.

(14) AT THE REQUEST OF AN INDIVIDUAL COVERED UNDER A MEDICARE SELECT CERTIFICATE, A MEDICARE SELECT HEALTH CARE

CORPORATION SHALL MAKE AVAILABLE TO THE INDIVIDUAL COVERED THE OPPORTUNITY TO PURCHASE A MEDICARE SUPPLEMENT CERTIFICATE OFFERED BY THE HEALTH CARE CORPORATION THAT HAS COMPARABLE OR LESSER BENEFITS AND THAT DOES NOT CONTAIN A RESTRICTED NETWORK PROVISION. THE HEALTH CARE CORPORATION SHALL MAKE THE CERTIFICATES AVAILABLE WITHOUT REQUIRING EVIDENCE OF INSURABILITY AFTER THE MEDICARE SUPPLEMENT CERTIFICATE HAS BEEN IN FORCE FOR 6 MONTHS. FOR THE PURPOSES OF THIS SUBSECTION, A MEDICARE SUPPLEMENT CERTIFICATE SHALL BE CONSIDERED TO HAVE COMPARABLE OR LESSER BENEFITS UNLESS IT CONTAINS 1 OR MORE SIGNIFICANT BENEFITS NOT INCLUDED IN THE MEDICARE SELECT CERTIFICATE BEING REPLACED. FOR THE PURPOSES OF THIS SUBSECTION, A SIGNIFICANT BENEFIT MEANS COVERAGE FOR THE MEDICARE PART A DEDUCTIBLE, COVERAGE FOR OUTPATIENT PRESCRIPTION DRUGS, COVERAGE FOR AT-HOME RECOVERY SERVICES, OR COVERAGE FOR PART B EXCESS CHARGES.

(15) MEDICARE SELECT CERTIFICATES SHALL PROVIDE FOR CONTINUATION OF COVERAGE IF THE SECRETARY OF HEALTH AND HUMAN SERVICES DETERMINES THAT MEDICARE SELECT CERTIFICATES ISSUED PURSUANT TO THIS SECTION SHOULD BE DISCONTINUED DUE TO EITHER THE FAILURE OF THE MEDICARE SELECT PROGRAM TO BE REAUTHORIZED UNDER LAW OR ITS SUBSTANTIAL AMENDMENT. EACH MEDICARE SELECT HEALTH CARE CORPORATION SHALL MAKE AVAILABLE TO EACH MEMBER COVERED UNDER A MEDICARE SELECT CERTIFICATE THE OPPORTUNITY TO PURCHASE ANY MEDICARE SUPPLEMENT CERTIFICATE OFFERED BY THE HEALTH CARE CORPORATION THAT HAS COMPARABLE OR LESSER BENEFITS AND THAT DOES NOT CONTAIN A RESTRICTED NETWORK PROVISION. THE ISSUER SHALL MAKE THE CERTIFICATES AVAILABLE WITHOUT REQUIRING EVIDENCE OF

INSURABILITY. FOR THE PURPOSES OF THIS SUBSECTION, A MEDICARE SUPPLEMENT CERTIFICATE WILL BE CONSIDERED TO HAVE COMPARABLE OR LESSER BENEFITS UNLESS IT CONTAINS 1 OR MORE SIGNIFICANT BENEFITS NOT INCLUDED IN THE MEDICARE SELECT CERTIFICATE BEING REPLACED. FOR THE PURPOSES OF THIS SUBSECTION, A SIGNIFICANT BENEFIT MEANS COVERAGE FOR THE MEDICARE PART A DEDUCTIBLE, COVERAGE FOR PRESCRIPTION DRUGS, COVERAGE FOR AT-HOME RECOVERY SERVICE OR COVERAGE FOR PART B EXCESS CHARGES.

(16) A MEDICARE SELECT HEALTH CARE CORPORATION SHALL COMPLY WITH REASONABLE REQUESTS FOR DATA MADE BY STATE OR FEDERAL AGENCIES, INCLUDING THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, FOR THE PURPOSES OF EVALUATING THE MEDICARE SELECT PROGRAM.

SEC. 469. (1) A CERTIFICATE SHALL NOT BE TITLED, ADVERTISED, SOLICITED, OR ISSUED FOR DELIVERY IN THIS STATE AS A MEDICARE SUPPLEMENT CERTIFICATE IF THE CERTIFICATE DOES NOT MEET THE MINIMUM STANDARDS PRESCRIBED IN THIS SECTION. THESE MINIMUM STANDARDS ARE IN ADDITION TO ALL OTHER REQUIREMENTS OF THIS PART.

(2) THE FOLLOWING STANDARDS APPLY TO MEDICARE SUPPLEMENT CERTIFICATES:

(A) A MEDICARE SUPPLEMENT CERTIFICATE SHALL NOT DENY A CLAIM FOR LOSSES INCURRED MORE THAN 6 MONTHS FROM THE EFFECTIVE DATE OF COVERAGE BECAUSE IT INVOLVED A PREEXISTING CONDITION. THE CERTIFICATE SHALL NOT DEFINE A PREEXISTING CONDITION MORE RESTRICTIVELY THAN TO MEAN A CONDITION FOR WHICH MEDICAL ADVICE WAS

GIVEN OR TREATMENT WAS RECOMMENDED BY OR RECEIVED FROM A PHYSICIAN WITHIN 6 MONTHS BEFORE THE EFFECTIVE DATE OF COVERAGE.

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

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

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

(E) TERMINATION OF A MEDICARE SUPPLEMENT CERTIFICATE SHALL NOT REDUCE OR LIMIT THE PAYMENT OF BENEFITS FOR ANY CONTINUOUS LOSS THAT COMMENCED WHILE THE CERTIFICATE WAS IN FORCE, BUT THE EXTENSION OF BENEFITS BEYOND THE PERIOD DURING WHICH THE CERTIFICATE WAS IN FORCE MAY BE PREDICATED UPON THE CONTINUOUS TOTAL DISABILITY OF THE MEMBER, LIMITED TO THE DURATION OF THE CERTIFICATE BENEFIT PERIOD, IF ANY, OR PAYMENT OF THE MAXIMUM BENEFITS.

(F) A MEDICARE SUPPLEMENT CERTIFICATE SHALL NOT PROVIDE FOR TERMINATION OF COVERAGE OF A SPOUSE SOLELY BECAUSE OF THE OCCURRENCE OF AN EVENT SPECIFIED FOR TERMINATION OF COVERAGE OF THE MEMBER, OTHER THAN THE NONPAYMENT OF PREMIUM.

(3) A MEDICARE SUPPLEMENT CERTIFICATE SHALL PROVIDE THAT BENEFITS AND PREMIUMS UNDER THE CERTIFICATE SHALL BE SUSPENDED AT

THE REQUEST OF THE CERTIFICATE HOLDER FOR A PERIOD NOT TO EXCEED 24 MONTHS IN WHICH THE CERTIFICATE HOLDER HAS APPLIED FOR AND IS DETERMINED TO BE ENTITLED TO MEDICAL ASSISTANCE UNDER MEDICAID, BUT ONLY IF THE CERTIFICATE HOLDER NOTIFIES THE HEALTH CARE CORPORATION OF SUCH ASSISTANCE WITHIN 90 DAYS AFTER THE DATE THE INDIVIDUAL BECOMES ENTITLED TO THE ASSISTANCE. UPON RECEIPT OF TIMELY NOTICE, THE HEALTH CARE CORPORATION SHALL RETURN TO THE CERTIFICATE HOLDER THAT PORTION OF THE PREMIUM ATTRIBUTABLE TO THE PERIOD OF MEDICAID ELIGIBILITY, SUBJECT TO ADJUSTMENT FOR PAID CLAIMS. IF A SUSPENSION OCCURS AND IF THE CERTIFICATE HOLDER LOSES ENTITLEMENT TO MEDICAL ASSISTANCE UNDER MEDICAID, THE CERTIFICATE SHALL BE AUTOMATICALLY REINSTITUTED EFFECTIVE AS OF THE DATE OF TERMINATION OF THE ASSISTANCE IF THE CERTIFICATE HOLDER PROVIDES NOTICE OF LOSS OF MEDICAID MEDICAL ASSISTANCE WITHIN 90 DAYS AFTER THE DATE OF THE LOSS AND PAYS THE PREMIUM ATTRIBUTABLE TO THE PERIOD EFFECTIVE AS OF THE DATE OF TERMINATION OF THE ASSISTANCE. ALL OF THE FOLLOWING APPLY TO THE REINSTITUTION OF A MEDICARE SUPPLEMENT CERTIFICATE UNDER THIS SUBSECTION:

(*i*) THE REINSTITUTION SHALL NOT PROVIDE FOR ANY WAITING PERIOD WITH RESPECT TO TREATMENT OF PREEXISTING CONDITIONS.

(*ii*) REINSTITUTED COVERAGE SHALL BE SUBSTANTIALLY EQUIVALENT TO COVERAGE IN EFFECT BEFORE THE DATE OF THE SUSPENSION.

(*iii*) CLASSIFICATION OF PREMIUMS FOR REINSTITUTED COVERAGE SHALL BE ON TERMS AT LEAST AS FAVORABLE TO THE CERTIFICATE HOLDER AS THE PREMIUM CLASSIFICATION TERMS THAT WOULD HAVE APPLIED TO THE CERTIFICATE HOLDER HAD THE COVERAGE NOT BEEN SUSPENDED.

SEC. 471. (1) A HEALTH CARE CORPORATION SHALL NOT ISSUE A NONGROUP MEDICARE SUPPLEMENT CERTIFICATE TO A PERSON WHO HAS NOT APPLIED FOR OR ENROLLED IN MEDICARE, PARTS A AND B. IF IT IS LATER DETERMINED THAT A PERSON HAS NOT APPLIED FOR OR ENROLLED IN MEDICARE, PARTS A AND B, A HEALTH CARE CORPORATION SHALL REFUND ALL PREMIUMS RECEIVED FROM THE PERSON FOR A MEDICARE SUPPLEMENT CERTIFICATE ISSUED TO THE PERSON PLUS INTEREST LESS THE AMOUNT OF ANY BENEFITS RECEIVED BY THE PERSON UNDER THE CERTIFICATE.

(2) INTEREST UNDER SUBSECTION (1) SHALL BE CALCULATED AT 6-MONTH INTERVALS FROM THE DATE THE FIRST PREMIUM PAYMENT WAS RECEIVED AT A RATE OF INTEREST EQUAL TO 1% PLUS THE AVERAGE INTEREST RATE PAID AT AUCTIONS OF 5-YEAR UNITED STATES TREASURY NOTES DURING THE 6 MONTHS IMMEDIATELY PRECEDING JULY 1 AND JANUARY 1, AS CERTIFIED BY THE STATE TREASURER, AND COMPOUNDED ANNUALLY.

SEC. 473. A HEALTH CARE CORPORATION CERTIFICATE SHALL NOT BE TITLED, ADVERTISED, SOLICITED, OR ISSUED FOR DELIVERY IN THIS STATE AS A MEDICARE SUPPLEMENT CERTIFICATE UNLESS THE DEFINITIONS AND TERMS CONTAINED IN THE CERTIFICATE ARE SUCH THAT COVERED BENEFITS UNDER THE CERTIFICATE ARE NOT MORE RESTRICTIVE THAN COVERED BENEFITS UNDER MEDICARE AND THOSE REQUIRED TO BE PROVIDED UNDER STATE LAW. A MEDICARE SUPPLEMENT CERTIFICATE SHALL CONTAIN A DEFINITION OF MEDICARE AS THAT TERM IS DEFINED IN SECTION 451 OR SUBSTANTIALLY SIMILAR TO THAT DEFINITION.

SEC. 475. A MEDICARE SUPPLEMENT CERTIFICATE SHALL NOT USE WAIVERS TO EXCLUDE, LIMIT, OR REDUCE COVERAGE OR BENEFITS FOR

SPECIFICALLY NAMED OR DESCRIBED PREEXISTING DISEASES OR PHYSICAL CONDITIONS.

SEC. 477. (1) A MEDICARE SUPPLEMENT CERTIFICATE SHALL NOT BE DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE IF THE CERTIFICATE PROVIDES BENEFITS THAT DUPLICATE BENEFITS PROVIDED BY MEDICARE.

(2) APPLICATION FORMS OR A SUPPLEMENTARY APPLICATION OR OTHER FORM TO BE SIGNED BY THE APPLICANT AND AGENT FOR MEDICARE SUPPLEMENT CERTIFICATES SHALL INCLUDE THE FOLLOWING STATEMENTS AND QUESTIONS DESIGNED TO INFORM AND ELICIT INFORMATION AS TO WHETHER, AS OF THE DATE OF THE APPLICATION, THE APPLICANT HAS ANOTHER MEDICARE SUPPLEMENT OR OTHER HEALTH INSURANCE POLICY, CONTRACT, OR CERTIFICATE IN FORCE OR WHETHER A MEDICARE SUPPLEMENT CERTIFICATE IS INTENDED TO REPLACE ANY DISABILITY OR OTHER HEALTH CERTIFICATE PRESENTLY IN FORCE:

[STATEMENTS]

(1) YOU DO NOT NEED MORE THAN 1 MEDICARE SUPPLEMENT CERTIFICATE.

(2) IF YOU ARE 65 OR OLDER, YOU MAY BE ELIGIBLE FOR BENEFITS UNDER MEDICAID AND MAY NOT NEED A MEDICARE SUPPLEMENT CERTIFICATE.

(3) THE BENEFITS AND PREMIUMS UNDER YOUR MEDICARE SUPPLEMENT CERTIFICATE WILL BE SUSPENDED DURING YOUR ENTITLEMENT TO BENEFITS UNDER MEDICAID FOR 24 MONTHS. YOU MUST REQUEST THIS SUSPENSION WITHIN 90 DAYS OF BECOMING ELIGIBLE FOR MEDICAID. IF YOU ARE NO LONGER ENTITLED TO MEDICAID, YOUR CERTIFICATE WILL BE

REINSTITUTED IF REQUESTED WITHIN 90 DAYS OF LOSING MEDICAID ELIGIBILITY.

(4) COUNSELING SERVICES MAY BE AVAILABLE IN YOUR STATE TO PROVIDE ADVICE CONCERNING YOUR PURCHASE OF MEDICARE SUPPLEMENT COVERAGE AND CONCERNING MEDICAID.

[QUESTIONS]

THESE QUESTIONS SHOULD BE ANSWERED TO THE BEST OF YOUR KNOWLEDGE.

(1) DO YOU HAVE ANOTHER MEDICARE SUPPLEMENT INSURANCE POLICY, CONTRACT, OR CERTIFICATE IN FORCE (INCLUDING AN INSURANCE POLICY OR HEALTH MAINTENANCE ORGANIZATION CONTRACT)? IF SO, WITH WHICH COMPANY?

(2) DO YOU HAVE ANY OTHER HEALTH INSURANCE POLICIES, CERTIFICATES, OR CONTRACTS THAT PROVIDE BENEFITS THAT THIS MEDICARE SUPPLEMENT CERTIFICATE WOULD DUPLICATE? IF SO, WITH WHICH COMPANY? WHAT KIND OF POLICY, CONTRACT, OR CERTIFICATE?

(3) IF THE ANSWER TO QUESTION 1 OR 2 IS YES, DO YOU INTEND TO REPLACE THESE DISABILITY OR HEALTH POLICIES, CERTIFICATES, OR CONTRACTS WITH THIS CERTIFICATE?

(4) ARE YOU COVERED BY MEDICAID?

(3) AN AGENT SHALL LIST ON THE APPLICATION FORM FOR A MEDICARE SUPPLEMENT CERTIFICATE ANY OTHER HEALTH INSURANCE POLICIES, CERTIFICATES, OR CONTRACTS HE OR SHE HAS SOLD TO THE APPLICANT, INCLUDING POLICIES, CERTIFICATES, OR CONTRACTS SOLD THAT ARE STILL IN FORCE AND POLICIES, CERTIFICATES, AND CONTRACTS SOLD IN THE PAST 5 YEARS THAT ARE NO LONGER IN FORCE.

(4) FOR A DIRECT RESPONSE HEALTH CARE CORPORATION, A COPY OF THE APPLICATION OR SUPPLEMENT FORM, SIGNED BY THE APPLICANT, AND ACKNOWLEDGED BY THE HEALTH CARE CORPORATION, SHALL BE RETURNED TO THE APPLICANT BY THE HEALTH CARE CORPORATION UPON DELIVERY OF THE CERTIFICATE.

(5) UPON DETERMINING THAT A SALE WILL INVOLVE REPLACEMENT OF MEDICARE SUPPLEMENT COVERAGE, A HEALTH CARE CORPORATION, OTHER THAN A DIRECT RESPONSE HEALTH CARE CORPORATION OR ITS AGENT, SHALL FURNISH THE APPLICANT PRIOR TO ISSUANCE OR DELIVERY OF THE MEDICARE SUPPLEMENT CERTIFICATE THE FOLLOWING NOTICE REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT COVERAGE. ONE COPY OF THE NOTICE SIGNED BY THE APPLICANT AND THE AGENT, EXCEPT WHERE COVERAGE IS SOLD WITHOUT AN AGENT, SHALL BE PROVIDED TO THE APPLICANT AND AN ADDITIONAL SIGNED COPY SHALL BE RETAINED BY THE HEALTH CARE CORPORATION. A DIRECT RESPONSE HEALTH CARE CORPORATION SHALL DELIVER TO THE APPLICANT AT THE TIME OF ISSUANCE OF THE CERTIFICATE THE FOLLOWING NOTICE REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT COVERAGE. THE NOTICE REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT COVERAGE SHALL BE PROVIDED IN SUBSTANTIALLY THE FOLLOWING FORM AND IN NOT LESS THAN 10-POINT TYPE:

"NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT COVERAGE
(HEALTH CARE CORPORATION'S NAME AND ADDRESS)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

ACCORDING TO (YOUR APPLICATION) (INFORMATION YOU HAVE FURNISHED), YOU INTEND TO DROP OR OTHERWISE TERMINATE EXISTING MEDICARE SUPPLEMENT COVERAGE AND REPLACE IT WITH A CERTIFICATE TO

BE ISSUED BY (HEALTH CARE CORPORATION NAME). YOUR NEW CERTIFICATE PROVIDES 30 DAYS WITHIN WHICH YOU MAY DECIDE WITHOUT COST WHETHER YOU DESIRE TO KEEP THE CERTIFICATE.

YOU SHOULD REVIEW THIS NEW COVERAGE CAREFULLY COMPARING IT WITH ALL DISABILITY AND OTHER HEALTH COVERAGE YOU NOW HAVE AND TERMINATE YOUR PRESENT COVERAGE ONLY IF, AFTER DUE CONSIDERATION, YOU FIND THAT PURCHASE OF THIS MEDICARE SUPPLEMENT COVERAGE IS A WISE DECISION.

STATEMENT TO APPLICANT BY HEALTH CARE CORPORATION, AGENT, OR OTHER REPRESENTATIVE:

(USE ADDITIONAL SHEETS AS NECESSARY.)

I HAVE REVIEWED YOUR CURRENT MEDICAL OR HEALTH COVERAGE. THE REPLACEMENT OF COVERAGE INVOLVED IN THIS TRANSACTION DOES NOT DUPLICATE COVERAGE, TO THE BEST OF MY KNOWLEDGE. THE REPLACEMENT CERTIFICATE IS BEING PURCHASED FOR THE FOLLOWING REASONS (CHECK 1):

_____ ADDITIONAL BENEFITS

_____ NO CHANGE IN BENEFITS, BUT LOWER PREMIUMS

_____ FEWER BENEFITS AND LOWER PREMIUMS

_____ OTHER. (PLEASE SPECIFY)

1. HEALTH CONDITIONS THAT YOU MAY PRESENTLY HAVE (PRE-EXISTING CONDITIONS) MAY NOT BE IMMEDIATELY OR FULLY COVERED UNDER THE NEW CERTIFICATE. THIS COULD RESULT IN DENIAL OR DELAY OF A CLAIM FOR BENEFITS UNDER THE NEW CERTIFICATE, WHEREAS A SIMILAR CLAIM MIGHT HAVE BEEN PAYABLE UNDER YOUR PRESENT POLICY, CONTRACT, OR CERTIFICATE. (THIS PARAGRAPH MAY BE DELETED BY A

HEALTH CARE CORPORATION IF THE REPLACEMENT DOES NOT INVOLVE APPLICATION OF A NEW PRE-EXISTING CONDITION LIMITATION.)

2. YOUR HEALTH CARE CORPORATION WILL WAIVE ANY TIME PERIODS APPLICABLE TO PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS, OR PROBATIONARY PERIODS IN THE NEW CERTIFICATE FOR SIMILAR BENEFITS TO THE EXTENT SUCH TIME WAS SPENT OR DEPLETED UNDER THE ORIGINAL COVERAGE. (THIS PARAGRAPH MAY BE DELETED BY A HEALTH CARE CORPORATION IF THE REPLACEMENT DOES NOT INVOLVE APPLICATION OF A NEW PREEXISTING CONDITION LIMITATION.)

3. IF, AFTER THINKING ABOUT IT CAREFULLY, YOU STILL WISH TO DROP YOUR PRESENT COVERAGE AND REPLACE IT WITH NEW COVERAGE, BE CERTAIN TO TRUTHFULLY AND COMPLETELY ANSWER ALL QUESTIONS ON THE APPLICATION CONCERNING YOUR MEDICAL AND HEALTH HISTORY. FAILURE TO INCLUDE ALL MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE HEALTH CARE CORPORATION TO DENY ANY FUTURE CLAIMS AND TO REFUND YOUR PREMIUM AS THOUGH YOUR CERTIFICATE HAD NEVER BEEN IN FORCE. AFTER THE APPLICATION HAS BEEN COMPLETED, AND BEFORE YOU SIGN IT, REVIEW IT CAREFULLY TO BE CERTAIN THAT ALL INFORMATION HAS BEEN PROPERLY RECORDED. (IF THE CERTIFICATE IS GUARANTEED ISSUE, THIS PARAGRAPH NEED NOT APPEAR.)

4. DO NOT CANCEL YOUR PRESENT POLICY, CONTRACT, OR CERTIFICATE UNTIL YOU HAVE RECEIVED YOUR NEW CERTIFICATE AND ARE SURE THAT YOU WANT TO KEEP IT.

_____

SIGNATURE OF AGENT, BROKER, OR OTHER REPRESENTATIVE

(* SIGNATURE NOT REQUIRED FOR DIRECT RESPONSE

SALES.)

_____

TYPED NAME AND ADDRESS OF AGENT OR BROKER

_____

(DATE)

THE ABOVE "NOTICE TO APPLICANT" WAS DELIVERED TO ME ON:

_____

(DATE)

_____

(APPLICANT'S SIGNATURE)

_____

(APPLICANT'S PRINTED NAME)

_____

(APPLICANT'S ADDRESS)

_____

(POLICY, CERTIFICATE, OR CONTRACT NUMBER BEING REPLACED)"

SEC. 479. A HEALTH CARE CORPORATION SHALL NOT DENY OR CONDITION THE ISSUANCE OR EFFECTIVENESS OF A MEDICARE SUPPLEMENT CERTIFICATE AVAILABLE FOR SALE IN THIS STATE, OR DISCRIMINATE IN THE PRICING OF SUCH A CERTIFICATE, BECAUSE OF THE HEALTH STATUS, CLAIMS EXPERIENCE, RECEIPT OF HEALTH CARE, OR MEDICAL CONDITION OF AN APPLICANT IF AN APPLICATION FOR THE CERTIFICATE IS SUBMITTED DURING THE 6-MONTH PERIOD BEGINNING WITH THE FIRST MONTH IN WHICH AN INDIVIDUAL WHO IS 65 YEARS OF AGE OR OLDER FIRST ENROLLED FOR BENEFITS UNDER MEDICARE PART B. EACH MEDICARE SUPPLEMENT CERTIFICATE CURRENTLY AVAILABLE FROM A HEALTH CARE CORPORATION SHALL BE MADE AVAILABLE TO ALL APPLICANTS WHO QUALIFY UNDER THIS SECTION WITHOUT REGARD TO AGE.

SEC. 481. (1) EACH HEALTH CARE CORPORATION OFFERING NONGROUP OR GROUP CERTIFICATES IN THIS STATE SHALL PROVIDE

WITHOUT RESTRICTION, TO ANY PERSON WHO REQUESTS COVERAGE FROM A HEALTH CARE CORPORATION AND HAS BEEN COVERED BY AN INSURER, HEALTH MAINTENANCE ORGANIZATION, OR HEALTH CARE CORPORATION IF THE PERSON WOULD NO LONGER BE COVERED BECAUSE HE OR SHE HAS BECOME ELIGIBLE FOR MEDICARE OR IF THE PERSON LOSES COVERAGE UNDER A GROUP CERTIFICATE AFTER BECOMING ELIGIBLE FOR MEDICARE, A RIGHT OF CONTINUATION OR CONVERSION TO THEIR CHOICE OF THE BASIC CORE BENEFITS AS DESCRIBED IN SECTION 455 OR A TYPE C MEDICARE SUPPLEMENTAL PACKAGE AS DESCRIBED IN SECTION 461(5)(C) THAT IS GUARANTEED RENEWABLE OR NONCANCELLABLE. A PERSON WHO IS HOSPITALIZED OR HAS BEEN INFORMED BY A PHYSICIAN THAT HE OR SHE WILL REQUIRE HOSPITALIZATION WITHIN 30 DAYS AFTER THE TIME OF APPLICATION SHALL NOT BE ENTITLED TO COVERAGE UNDER THIS SUBSECTION UNTIL THE DAY FOLLOWING THE DATE OF DISCHARGE. HOWEVER, IF THE HOSPITALIZED PERSON WAS COVERED BY THE HEALTH CARE CORPORATION IMMEDIATELY PRIOR TO BECOMING ELIGIBLE FOR MEDICARE OR IMMEDIATELY PRIOR TO LOSING COVERAGE UNDER A GROUP CERTIFICATE AFTER BECOMING ELIGIBLE FOR MEDICARE, THE PERSON SHALL BE ELIGIBLE FOR IMMEDIATE COVERAGE FROM THE PREVIOUS INSURER, HEALTH MAINTENANCE ORGANIZATION, OR HEALTH CARE CORPORATION UNDER THIS SUBSECTION. A PERSON SHALL NOT BE ENTITLED TO A MEDICARE SUPPLEMENTAL CERTIFICATE UNDER THIS SUBSECTION UNLESS THE PERSON PRESENTS SATISFACTORY PROOF TO THE HEALTH CARE CORPORATION THAT HE OR SHE WAS COVERED BY AN INSURER, HEALTH MAINTENANCE ORGANIZATION, OR HEALTH CARE CORPORATION. A PERSON WHO WISHES COVERAGE UNDER THIS SUBSECTION MUST EITHER REQUEST COVERAGE WITHIN 90 DAYS BEFORE OR 90 DAYS AFTER THE MONTH HE OR SHE BECOMES ELIGIBLE FOR MEDICARE OR

REQUEST COVERAGE WITHIN 180 DAYS AFTER LOSING COVERAGE UNDER A GROUP POLICY, CONTRACT, OR CERTIFICATE. A PERSON 60 YEARS OF AGE OR OLDER WHO LOSES COVERAGE UNDER A GROUP POLICY OR CERTIFICATE IS ENTITLED TO COVERAGE UNDER A MEDICARE SUPPLEMENTAL CERTIFICATE WITHOUT RESTRICTION FROM THE HEALTH CARE CORPORATION PROVIDING THE FORMER GROUP COVERAGE, IF HE OR SHE REQUESTS COVERAGE WITHIN 90 DAYS BEFORE OR 90 DAYS AFTER THE MONTH HE OR SHE BECOMES ELIGIBLE FOR MEDICARE.

(2) EXCEPT AS PROVIDED IN SECTION 483, A PERSON NOT COVERED UNDER A NONGROUP OR GROUP CERTIFICATE AS SPECIFIED IN SUBSECTION (1), AFTER APPLYING FOR COVERAGE UNDER A MEDICARE SUPPLEMENTAL CERTIFICATE REQUIRED TO BE OFFERED UNDER SUBSECTION (1), IS ENTITLED TO COVERAGE UNDER A MEDICARE SUPPLEMENTAL CERTIFICATE THAT MAY INCLUDE A PROVISION FOR EXCLUSION FROM PREEXISTING CONDITIONS FOR 6 MONTHS AFTER THE INCEPTION OF COVERAGE, CONSISTENT WITH THE PROVISIONS OF SECTION 469(2)(A).

(3) EACH HEALTH CARE CORPORATION OFFERING NONGROUP CERTIFICATES IN THIS STATE SHALL GIVE TO EACH PERSON WHO IS COVERED WITH THE HEALTH CARE CORPORATION AT THE TIME HE OR SHE BECOMES ELIGIBLE FOR MEDICARE, AND TO EACH APPLICANT OF THE HEALTH CARE CORPORATION WHO IS ELIGIBLE FOR MEDICARE, WRITTEN NOTICE OF THE AVAILABILITY OF COVERAGE UNDER THIS SECTION. EACH GROUP CERTIFICATE HOLDER IN THIS STATE SHALL GIVE TO EACH MEMBER WHO IS COVERED AT THE TIME HE OR SHE BECOMES ELIGIBLE FOR MEDICARE, WRITTEN NOTICE OF THE AVAILABILITY OF COVERAGE UNDER THIS SECTION.

SEC. 483. IF A MEDICARE SUPPLEMENT CERTIFICATE REPLACES ANOTHER MEDICARE SUPPLEMENT POLICY, CONTRACT, OR CERTIFICATE, THE

REPLACING HEALTH CARE CORPORATION SHALL WAIVE ANY TIME PERIODS APPLICABLE TO PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS, AND PROBATIONARY PERIODS IN THE NEW MEDICARE SUPPLEMENT CERTIFICATE FOR SIMILAR BENEFITS TO THE EXTENT SUCH TIME WAS SPENT UNDER THE ORIGINAL COVERAGE.

SEC. 485. (1) EACH HEALTH CARE CORPORATION MARKETING MEDICARE SUPPLEMENT COVERAGE IN THIS STATE DIRECTLY OR THROUGH ITS AGENTS SHALL DO ALL OF THE FOLLOWING:

(A) ESTABLISH MARKETING PROCEDURES TO ENSURE THAT ANY COMPARISON OF POLICIES BY ITS AGENTS WILL BE FAIR AND ACCURATE.

(B) ESTABLISH MARKETING PROCEDURES TO ENSURE EXCESSIVE COVERAGE IS NOT SOLD OR ISSUED.

(C) INQUIRE AND OTHERWISE MAKE EVERY REASONABLE EFFORT TO IDENTIFY WHETHER A PROSPECTIVE APPLICANT FOR MEDICARE SUPPLEMENT COVERAGE ALREADY HAS DISABILITY OR OTHER HEALTH COVERAGE AND THE TYPES AND AMOUNTS OF COVERAGE.

(D) ESTABLISH AUDITABLE PROCEDURES FOR VERIFYING COMPLIANCE WITH THIS SUBSECTION.

(2) IN RECOMMENDING THE PURCHASE OR REPLACEMENT OF ANY MEDICARE SUPPLEMENT COVERAGE, AN AGENT SHALL MAKE REASONABLE EFFORTS TO DETERMINE THE APPROPRIATENESS OF A RECOMMENDED PURCHASE OR REPLACEMENT.

(3) ANY SALE OF MEDICARE SUPPLEMENT COVERAGE THAT WILL PROVIDE AN INDIVIDUAL WITH MORE THAN 1 MEDICARE SUPPLEMENT POLICY, CONTRACT, OR CERTIFICATE IS PROHIBITED.

(4) A MEDICAL SUPPLEMENT CERTIFICATE SHALL DISPLAY PROMINENTLY BY TYPE, STAMP, OR OTHER APPROPRIATE MEANS, ON THE

FIRST PAGE OF THE CERTIFICATE THE FOLLOWING: "NOTICE TO BUYER: THIS CERTIFICATE MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES."

SEC. 487. (1) ON OR BEFORE MARCH 1 OF EACH YEAR, EVERY HEALTH CARE CORPORATION PROVIDING MEDICARE SUPPLEMENT COVERAGE IN THIS STATE SHALL REPORT TO THE COMMISSIONER THE FOLLOWING INFORMATION FOR EVERY INDIVIDUAL RESIDENT OF THIS STATE FOR WHICH THE HEALTH CARE CORPORATION HAS IN FORCE MORE THAN 1 MEDICARE SUPPLEMENT CERTIFICATE:

(A) CERTIFICATE NUMBER.

(B) DATE OF ISSUANCE.

(2) THE ITEMS IN SUBSECTION (1) SHALL BE GROUPED BY INDIVIDUAL CERTIFICATE HOLDER.

SEC. 491. (1) EACH MEDICARE SUPPLEMENT CERTIFICATE SHALL INCLUDE A RENEWAL OR CONTINUATION PROVISION. THE PROVISION SHALL BE APPROPRIATELY CAPTIONED, SHALL APPEAR ON THE FIRST PAGE OF THE CERTIFICATE, AND SHALL CLEARLY STATE THE TERM OF COVERAGE FOR WHICH THE CERTIFICATE IS ISSUED AND FOR WHICH IT MAY BE RENEWED. THE PROVISION SHALL INCLUDE ANY RESERVATION BY THE HEALTH CARE CORPORATION OF THE RIGHT TO CHANGE PREMIUMS AND ANY AUTOMATIC RENEWAL PREMIUM INCREASES BASED ON THE CERTIFICATE HOLDER'S AGE.

(2) IF A MEDICARE SUPPLEMENT CERTIFICATE IS TERMINATED BY THE GROUP CERTIFICATE HOLDER AND IS NOT REPLACED AS PROVIDED UNDER SUBSECTION (4), THE HEALTH CARE CORPORATION SHALL OFFER CERTIFICATE HOLDERS A NONGROUP MEDICARE SUPPLEMENT CERTIFICATE THAT AT THE OPTION OF THE CERTIFICATE HOLDER PROVIDES FOR CONTINUATION OF THE BENEFITS CONTAINED IN THE GROUP CERTIFICATE OR

PROVIDES FOR SUCH BENEFITS AS OTHERWISE MEET THE REQUIREMENTS OF SECTION 469.

(3) IF AN INDIVIDUAL IS A CERTIFICATE HOLDER IN A GROUP MEDICARE SUPPLEMENT CERTIFICATE AND THE INDIVIDUAL TERMINATES MEMBERSHIP IN THE GROUP, THE HEALTH CARE CORPORATION SHALL OFFER THE CERTIFICATE HOLDER THE CONVERSION OPPORTUNITY DESCRIBED IN SUBSECTION (2) OR AT THE OPTION OF THE GROUP CERTIFICATE HOLDER, OFFER THE CERTIFICATE HOLDER CONTINUATION OF COVERAGE UNDER THE GROUP CERTIFICATE.

(4) IF A GROUP MEDICARE SUPPLEMENT POLICY, CONTRACT, OR CERTIFICATE IS REPLACED BY ANOTHER GROUP MEDICARE SUPPLEMENT POLICY, CONTRACT, OR CERTIFICATE PURCHASED BY THE SAME CERTIFICATE HOLDER, THE SUCCEEDING ISSUER SHALL OFFER COVERAGE TO ALL PERSONS COVERED UNDER THE OLD GROUP POLICY, CONTRACT, OR CERTIFICATE ON ITS DATE OF TERMINATION. COVERAGE UNDER THE NEW CERTIFICATE SHALL NOT RESULT IN ANY EXCLUSION FOR PREEXISTING CONDITIONS THAT WOULD HAVE BEEN COVERED UNDER THE GROUP POLICY, CONTRACT, OR CERTIFICATE BEING REPLACED.

SEC. 493. (1) EXCEPT FOR RIDERS OR ENDORSEMENTS BY WHICH THE HEALTH CARE CORPORATION EFFECTUATES A REQUEST MADE IN WRITING BY THE SUBSCRIBER, EXERCISES A SPECIFICALLY RESERVED RIGHT UNDER A MEDICARE SUPPLEMENT CERTIFICATE, OR AS REQUIRED TO REDUCE OR ELIMINATE BENEFITS TO AVOID DUPLICATION OF MEDICARE BENEFITS, ALL RIDERS OR ENDORSEMENTS ADDED TO A MEDICARE SUPPLEMENT CERTIFICATE AFTER DATE OF ISSUE OR AT REINSTATEMENT OR RENEWAL THAT REDUCE OR ELIMINATE BENEFITS OR COVERAGE IN THE CERTIFICATE SHALL REQUIRE SIGNED ACCEPTANCE BY THE SUBSCRIBER. AFTER THE DATE OF

CERTIFICATE ISSUE, ANY RIDER OR ENDORSEMENT THAT INCREASES BENEFITS OR COVERAGE WITH A CONCOMITANT INCREASE IN PREMIUM DURING THE CERTIFICATE TERM SHALL BE AGREED TO IN WRITING AND SIGNED BY THE SUBSCRIBER, UNLESS THE BENEFITS ARE REQUIRED MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT CERTIFICATES OR IF THE INCREASE IN BENEFITS OR COVERAGE IS REQUIRED BY LAW. IF A SEPARATE ADDITIONAL PREMIUM IS CHARGED FOR BENEFITS PROVIDED IN CONNECTION WITH RIDERS OR ENDORSEMENTS, THE PREMIUM CHARGED SHALL BE SET FORTH IN THE CERTIFICATE.

(2) A MEDICARE SUPPLEMENT CERTIFICATE SHALL NOT PROVIDE FOR THE PAYMENT OF BENEFITS BASED ON STANDARDS DESCRIBED AS "USUAL AND CUSTOMARY", "REASONABLE AND CUSTOMARY", OR WORDS OF SIMILAR IMPORT.

(3) IF A MEDICARE SUPPLEMENT CERTIFICATE CONTAINS ANY LIMITATIONS WITH RESPECT TO PREEXISTING CONDITIONS, THE LIMITATIONS SHALL APPEAR AS A SEPARATE PARAGRAPH OF THE CERTIFICATE AND SHALL BE LABELED AS "PREEXISTING CONDITION LIMITATIONS".

(4) THE TERM "MEDICARE SUPPLEMENT", "MEDIGAP", "MEDICARE WRAP-AROUND", OR WORDS OF SIMILAR IMPORT SHALL NOT BE USED UNLESS THE CERTIFICATE IS ISSUED IN COMPLIANCE WITH THIS PART.

(5) A MEDICARE SUPPLEMENT CERTIFICATE SHALL HAVE A NOTICE PROMINENTLY PRINTED ON THE FIRST PAGE OR ATTACHED THERETO STATING THAT A MEMBER SHALL HAVE THE RIGHT TO RETURN THE POLICY OR CERTIFICATE WITHIN 30 DAYS OF ITS DELIVERY AND TO HAVE THE PREMIUM REFUNDED IF, AFTER EXAMINATION OF THE CERTIFICATE, THE MEMBER IS NOT SATISFIED FOR ANY REASON.

(6) AS SOON AS PRACTICABLE BUT PRIOR TO THE EFFECTIVE DATE OF ANY CHANGES IN MEDICARE BENEFITS, EVERY HEALTH CARE CORPORATION OFFERING MEDICARE SUPPLEMENT COVERAGE IN THIS STATE SHALL FILE WITH THE COMMISSIONER ANY APPROPRIATE RIDERS, ENDORSEMENTS, OR CERTIFICATE FORMS NEEDED TO ACCOMPLISH THE MEDICARE SUPPLEMENT MODIFICATIONS NECESSARY TO ELIMINATE BENEFITS UNDER THE CERTIFICATE THAT DUPLICATE BENEFITS PROVIDED BY MEDICARE. THE RIDERS, ENDORSEMENTS, AND CERTIFICATE FORMS SHALL PROVIDE A CLEAR DESCRIPTION OF THE MEDICARE SUPPLEMENT BENEFITS PROVIDED BY THE CERTIFICATE.

(7) UPON SATISFYING THE FILING AND APPROVAL REQUIREMENTS, A HEALTH CARE CORPORATION PROVIDING MEDICARE SUPPLEMENT CERTIFICATES DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE SHALL PROVIDE TO EACH COVERED CERTIFICATE HOLDER ANY RIDER, ENDORSEMENT, OR CERTIFICATE FORM NECESSARY TO ELIMINATE BENEFITS UNDER THE CERTIFICATE THAT DUPLICATE BENEFITS PROVIDED BY MEDICARE.

(8) AS SOON AS PRACTICABLE BUT NO LATER THAN 30 DAYS BEFORE THE ANNUAL EFFECTIVE DATE OF ANY MEDICARE BENEFIT CHANGES, EVERY HEALTH CARE CORPORATION DELIVERING OR ISSUING FOR DELIVERY IN THIS STATE MEDICARE SUPPLEMENT CERTIFICATES SHALL NOTIFY EACH COVERED CERTIFICATE HOLDER OF MODIFICATIONS MADE TO ITS MEDICARE SUPPLEMENT CERTIFICATES IN A FORMAT ACCEPTABLE TO THE COMMISSIONER. THE NOTICE SHALL BE IN OUTLINE FORM, CONTAIN CLEAR AND SIMPLE LANGUAGE, SHALL NOT CONTAIN OR BE ACCOMPANIED BY ANY SOLICITATION, AND SHALL INCLUDE BOTH OF THE FOLLOWING:

(A) A DESCRIPTION OF REVISIONS TO THE MEDICARE PROGRAM AND OF EACH MODIFICATION MADE TO THE COVERAGE PROVIDED UNDER THE MEDICARE SUPPLEMENT CERTIFICATE.

(B) WHETHER A PREMIUM ADJUSTMENT IS DUE TO CHANGES IN MEDICARE.

SEC. 495. (1) ANY CERTIFICATE ISSUED FOR DELIVERY IN THIS STATE TO PERSONS ELIGIBLE FOR MEDICARE BY REASON OF AGE SHALL NOTIFY SUBSCRIBERS UNDER THE CERTIFICATE THAT THE CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. THE NOTICE SHALL EITHER BE PRINTED OR ATTACHED TO THE FIRST PAGE OF THE COVERAGE OUTLINE DELIVERED TO SUBSCRIBERS UNDER THE CERTIFICATE, OR IF A COVERAGE OUTLINE IS NOT DELIVERED, TO THE FIRST PAGE OF THE CERTIFICATE DELIVERED TO SUBSCRIBERS. THE NOTICE SHALL BE IN NOT LESS THAN 12-POINT TYPE, AND SHALL CONTAIN THE FOLLOWING LANGUAGE:

"THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. IT IS NOT DESIGNED TO FIT WITH MEDICARE. IT MAY NOT FIT ALL OF THE GAPS IN MEDICARE AND IT MAY DUPLICATE SOME MEDICARE BENEFITS. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE MEDICARE SUPPLEMENT BUYER'S GUIDE AVAILABLE FROM THE COMPANY. IF YOU DECIDE TO CONSIDER BUYING THIS CERTIFICATE, BE SURE YOU UNDERSTAND WHAT IT COVERS, WHAT IT DOES NOT COVER, AND WHETHER IT DUPLICATES COVERAGE YOU ALREADY HAVE."

(2) SUBSECTION (1) DOES NOT APPLY TO A MEDICARE SUPPLEMENT CERTIFICATE.

SEC. 496. THE FOLLOWING ACTS AND PRACTICES ARE PROHIBITED IN THE MARKETING OR SALE OF MEDICARE SUPPLEMENT COVERAGE:

(A) TWISTING. KNOWINGLY MAKING ANY MISLEADING REPRESENTATION OR INCOMPLETE OR FRAUDULENT COMPARISON OF ANY INSURANCE POLICIES, CERTIFICATES, OR CONTRACTS OF INSURERS, HEALTH CARE CORPORATIONS, OR HEALTH MAINTENANCE ORGANIZATIONS FOR THE PURPOSE OF INDUCING, OR TENDING TO INDUCE, ANY PERSON TO LAPSE, FORFEIT, SURRENDER, TERMINATE, RETAIN, PLEDGE, ASSIGN, BORROW ON, OR CONVERT ANY INSURANCE POLICY, CONTRACT, OR CERTIFICATE OR TO TAKE OUT A POLICY, CERTIFICATE, OR CONTRACT WITH ANOTHER INSURER, HEALTH CARE CORPORATION, OR HEALTH MAINTENANCE ORGANIZATION.

(B) HIGH PRESSURE TACTICS. EMPLOYING ANY METHOD OF MARKETING HAVING THE EFFECT OF OR TENDING TO INDUCE THE PURCHASE OF HEALTH COVERAGE THROUGH FORCE, FRIGHT, THREAT WHETHER EXPLICIT OR IMPLIED, OR UNDUE PRESSURE TO PURCHASE OR RECOMMEND THE PURCHASE OF HEALTH COVERAGE.

(C) COLD LEAD ADVERTISING. MAKING USE DIRECTLY OR INDIRECTLY OF ANY METHOD OF MARKETING THAT FAILS TO DISCLOSE IN A CONSPICUOUS MANNER THAT A PURPOSE OF THE METHOD OF MARKETING IS SOLICITATION OF HEALTH COVERAGE AND THAT CONTACT WILL BE MADE BY A HEALTH CARE CORPORATION AGENT OR COMPANY.

SEC. 497. EACH HEALTH CARE CORPORATION PROVIDING MEDICARE SUPPLEMENT COVERAGE IN THIS STATE SHALL FILE WITH THE COMMISSIONER FOR REVIEW A COPY OF ANY WRITTEN, RADIO, OR TELEVISION ADVERTISEMENT FOR MEDICARE SUPPLEMENT COVERAGE INTENDED FOR USE IN THIS STATE AT LEAST 45 DAYS BEFORE THE DATE THE HEALTH CARE CORPORATION DESIRES TO USE THE ADVERTISING. THE FILING SHALL INCLUDE A SAMPLE OR PHOTOCOPY OF ALL APPLICABLE MEDICARE

SUPPLEMENT CERTIFICATES AND RELATED FORMS AND THE APPROVAL STATUS OF THE CERTIFICATES AND FORMS.

SEC. 498. (1) A HEALTH CARE CORPORATION SHALL NOT DELIVER OR ISSUE FOR DELIVERY A MEDICARE SUPPLEMENT CERTIFICATE TO A RESIDENT OF THIS STATE UNLESS THE CERTIFICATE FORM HAS BEEN FILED WITH AND APPROVED BY THE COMMISSIONER IN ACCORDANCE WITH FILING REQUIREMENTS AND PROCEDURES PRESCRIBED BY THE COMMISSIONER.

(2) A HEALTH CARE CORPORATION SHALL NOT USE OR CHANGE PREMIUM RATES FOR A MEDICARE SUPPLEMENT CERTIFICATE UNLESS THE RATES, RATING SCHEDULE, AND SUPPORTING DOCUMENTATION HAVE BEEN FILED WITH AND APPROVED BY THE COMMISSIONER IN ACCORDANCE WITH THE FILING REQUIREMENTS AND PROCEDURES PRESCRIBED BY THE COMMISSIONER.

(3) EXCEPT AS PROVIDED IN SUBSECTION (4), A HEALTH CARE CORPORATION SHALL NOT FILE FOR APPROVAL MORE THAN 1 FORM OF A CERTIFICATE FOR EACH GROUP AND NONGROUP STANDARD MEDICARE SUPPLEMENT BENEFIT PLAN.

(4) WITH THE APPROVAL OF THE COMMISSIONER, A HEALTH CARE CORPORATION MAY OFFER UP TO 4 ADDITIONAL CERTIFICATE FORMS OF THE SAME TYPE FOR THE SAME STANDARD MEDICARE SUPPLEMENT BENEFIT PLAN, 1 FOR EACH OF THE FOLLOWING CASES:

(A) THE INCLUSION OF NEW OR INNOVATIVE BENEFITS.

(B) THE ADDITION OF EITHER DIRECT RESPONSE OR AGENT MARKETING METHODS.

(C) THE ADDITION OF EITHER GUARANTEED ISSUE OR UNDERWRITTEN COVERAGE.

(D) THE OFFERING OF COVERAGE TO INDIVIDUALS ELIGIBLE FOR MEDICARE BY REASON OF DISABILITY.

(5) EXCEPT AS PROVIDED IN SUBSECTION (6), A HEALTH CARE CORPORATION SHALL CONTINUE TO MAKE AVAILABLE FOR PURCHASE ANY MEDICARE SUPPLEMENT CERTIFICATE FORM ISSUED AFTER THE EFFECTIVE DATE OF THIS PART THAT HAS BEEN APPROVED BY THE COMMISSIONER. A MEDICARE SUPPLEMENT CERTIFICATE FORM SHALL NOT BE CONSIDERED TO BE AVAILABLE FOR PURCHASE UNLESS THE HEALTH CARE CORPORATION HAS ACTIVELY OFFERED IT FOR SALE IN THE PREVIOUS 12 MONTHS.

(6) A HEALTH CARE CORPORATION MAY DISCONTINUE THE AVAILABILITY OF A MEDICARE SUPPLEMENT CERTIFICATE FORM IF THE HEALTH CARE CORPORATION PROVIDES TO THE COMMISSIONER IN WRITING ITS DECISION TO DISCONTINUE AT LEAST 30 DAYS PRIOR TO DISCONTINUING THE AVAILABILITY OF THE FORM OF THE MEDICARE SUPPLEMENT CERTIFICATE. AFTER RECEIPT OF THE NOTICE BY THE COMMISSIONER, THE HEALTH CARE CORPORATION SHALL NO LONGER OFFER FOR SALE THE MEDICARE SUPPLEMENT CERTIFICATE FORM IN THIS STATE.

(7) A HEALTH CARE CORPORATION THAT DISCONTINUES THE AVAILABILITY OF A MEDICARE SUPPLEMENT CERTIFICATE FORM PURSUANT TO SUBSECTION (6) SHALL NOT FILE FOR APPROVAL A NEW MEDICARE SUPPLEMENT CERTIFICATE FORM OF THE SAME TYPE FOR THE SAME STANDARD MEDICARE SUPPLEMENT BENEFIT PLAN AS THE DISCONTINUED FORM FOR A PERIOD OF 5 YEARS AFTER THE HEALTH CARE CORPORATION PROVIDES NOTICE TO THE COMMISSIONER OF THE DISCONTINUANCE. THE PERIOD OF DISCONTINUANCE MAY BE REDUCED IF THE COMMISSIONER DETERMINES THAT A SHORTER PERIOD IS APPROPRIATE.

(8) THE SALE OR OTHER TRANSFER OF MEDICARE SUPPLEMENT BUSINESS TO ANOTHER INSURER, HEALTH MAINTENANCE ORGANIZATION, OR HEALTH CARE CORPORATION SHALL BE CONSIDERED A DISCONTINUANCE FOR THE PURPOSES OF THIS SECTION.

(9) EACH HEALTH CARE CORPORATION THAT ISSUES MEDICARE SUPPLEMENT CERTIFICATES FOR DELIVERY IN THIS STATE SHALL COMPLY WITH SECTIONS 1842 AND 1882 OF TITLE XVIII OF THE SOCIAL SECURITY ACT, CHAPTER 531, 49 STAT. 620, 42 U.S.C. 1395u AND 1395ss, AND SHALL CERTIFY THAT COMPLIANCE ON THE MEDICARE SUPPLEMENT EXPERIENCE REPORTING FORM.

(10) FOR THE PURPOSES OF THIS SECTION, "TYPE" MEANS A GROUP CERTIFICATE, A NONGROUP CERTIFICATE, A GROUP MEDICARE SELECT CERTIFICATE, OR A NONGROUP MEDICARE SELECT CERTIFICATE.

SEC. 499. (1) A HEALTH CARE CORPORATION SHALL DO ALL OF THE FOLLOWING:

(A) ACCEPT A NOTICE FROM A MEDICARE CARRIER ON DUALLY ASSIGNED CLAIMS SUBMITTED BY PARTICIPATING PHYSICIANS AND SUPPLIERS AS A CLAIM FOR BENEFITS IN PLACE OF ANY OTHER CLAIM FORM OTHERWISE REQUIRED AND MAKE A PAYMENT DETERMINATION ON THE BASIS OF THE INFORMATION CONTAINED IN THAT NOTICE.

(B) NOTIFY THE PARTICIPATING PHYSICIAN OR SUPPLIER AND THE BENEFICIARY OF THE PAYMENT DETERMINATION.

(C) PAY THE PARTICIPATING PHYSICIAN OR SUPPLIER DIRECTLY.

(D) AT THE TIME OF ENROLLMENT, FURNISH EACH ENROLLEE WITH A CARD LISTING THE CERTIFICATE NAME, NUMBER, AND A CENTRAL MAILING ADDRESS TO WHICH NOTICES FROM A MEDICARE CARRIER MAY BE SENT.

(E) PAY USER FEES FOR CLAIM NOTICES THAT ARE TRANSMITTED ELECTRONICALLY OR OTHERWISE.

(F) PROVIDE TO THE SECRETARY OF HEALTH AND HUMAN SERVICES, AT LEAST ANNUALLY, A CENTRAL MAILING ADDRESS TO WHICH ALL CLAIMS MAY BE SENT BY MEDICARE CARRIERS.

(2) COMPLIANCE WITH THE REQUIREMENTS SET FORTH IN SUBSECTION (1) SHALL BE CERTIFIED ON THE MEDICARE SUPPLEMENT INSURANCE EXPERIENCE REPORTING FORM.

SEC. 499A. (1) A PERSON SHALL NOT KNOWINGLY SELL A HEALTH CARE CORPORATION CERTIFICATE TO AN INDIVIDUAL ENTITLED TO BENEFITS UNDER PART A OR ENROLLED UNDER PART B OF MEDICARE WITH KNOWLEDGE THAT THE CERTIFICATE SUBSTANTIALLY DUPLICATES HEALTH BENEFITS TO WHICH THE INDIVIDUAL IS OTHERWISE ENTITLED, OTHER THAN BENEFITS TO WHICH THE INDIVIDUAL IS ENTITLED UNDER A REQUIREMENT OF STATE OR FEDERAL LAW OTHER THAN MEDICARE. A PERSON WHO VIOLATES THIS SUBSECTION IS GUILTY OF A MISDEMEANOR PUNISHABLE BY IMPRISONMENT FOR NOT MORE THAN 2 YEARS, OR A FINE OF NOT MORE THAN $10,000.00, OR BOTH. THE COURT MAY ORDER A PERSON CONVICTED UNDER THIS SUBSECTION TO PAY RESTITUTION TO INDIVIDUALS FOR EXPENSES INCURRED AS A RESULT OF VIOLATION OF THIS SUBSECTION. FOR PURPOSES OF THIS SUBSECTION, BENEFITS THAT ARE PAYABLE TO OR ON BEHALF OF AN INDIVIDUAL WITHOUT REGARD TO OTHER HEALTH BENEFIT COVERAGE OF THE INDIVIDUAL SHALL NOT BE CONSIDERED AS DUPLICATIVE. THE SELLING OF A GROUP CERTIFICATE OF THE TRUSTEES OF A FUND ESTABLISHED BY 1 OR MORE EMPLOYERS, LABOR ORGANIZATIONS, OR BOTH, FOR EMPLOYEES, FORMER EMPLOYEES, OR BOTH, OR FOR MEMBERS OR FORMER MEMBERS, OR BOTH, OF LABOR

ORGANIZATIONS, SHALL NOT BE CONSIDERED TO BE A VIOLATION OF THIS SUBSECTION.

(2) A PERSON SHALL NOT FALSELY ASSUME OR PRETEND TO BE ACTING OR MISREPRESENT IN ANY WAY THAT HE OR SHE IS ACTING UNDER THE AUTHORITY OF OR IN ASSOCIATION WITH MEDICARE OR ANY STATE OR FEDERAL AGENCY, FOR THE PURPOSE OF SELLING OR ATTEMPTING TO SELL HEALTH COVERAGE OR, IN SUCH A PRETENDED CHARACTER, DEMAND OR OBTAIN MONEY, PAPER, DOCUMENTS, OR ANY THING OF VALUE. A PERSON WHO VIOLATES THIS SUBSECTION IS GUILTY OF A MISDEMEANOR PUNISHABLE BY IMPRISONMENT FOR NOT MORE THAN 2 YEARS, OR A FINE OF NOT MORE THAN $10,000.00, OR BOTH.

(3) A PERSON SHALL NOT SOLICIT, OFFER FOR SALE, OR DELIVER A MEDICARE SUPPLEMENT CERTIFICATE IN THIS STATE, UNLESS THE CERTIFICATE HAS BEEN APPROVED BY THE COMMISSIONER. A PERSON WHO VIOLATES THIS SUBSECTION IS GUILTY OF A MISDEMEANOR PUNISHABLE BY IMPRISONMENT FOR NOT MORE THAN 1 YEAR, OR A FINE OF NOT MORE THAN $5,000.00, OR BOTH.

Section 2. Sections 411 to 413a of Act No. 350 of the Public Acts of 1980, being sections 550.1411 to 550.1413a of the Michigan Compiled Laws, are repealed.