

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:

5 Sec. 202. (1) Persons associating to form a health care 6 corporation under this act shall subscribe to articles of 7 incorporation that shall contain all of the following:

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(a) The names and addresses of the incorporators.

2 (b) The location of the principal office of the corporation3 for the transaction of business in this state.

4 (c) The name by which the corporation shall be known and all 5 assumed names under which the corporation does business. The 6 corporate name shall not include the words insurance, casualty, 7 surety, health and accident, mutual, or other words descriptive 8 of the insurance or surety business, and shall not be so similar 9 to the name of an insurance or surety company doing business in 10 this or other states at the time of incorporation so as to tend, 11 in the judgment of the commissioner, to create confusion in iden-12 tity 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
16 for a certificate the opportunity for access to coverage for
17 health care services at a fair and reasonable price.

18 (*iii*) To assure for nongroup and group subscribers reason19 able access to, and reasonable cost and quality of, health care
20 services.

21 (*iv*) To achieve the goals of the corporation relative to 22 access, quality, and cost of health care services, as prescribed 23 in section 504.

24 (v) To offer supplemental coverage to all medicare enrollees 25 as provided in <u>section 411</u> PART 4A.

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

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

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

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

12 (e) The term of existence of the corporation, which may be13 in perpetuity.

14 (f) The time for the holding of the annual meeting of the15 corporation.

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

19 (2) The articles shall be in triplicate and upon proper20 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 attoraney 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.

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(4) Each health care corporation shall pay a fee of \$250.00
2 to the attorney general for the examination of its articles of
3 incorporation, or \$100.00 for the examination of amendments to
4 the articles of incorporation. Each health care corporation
5 shall pay a filing fee of \$100.00 to the commissioner for filing
6 its articles of incorporation or \$50.00 for the filing of amend7 ments to the articles of incorporation. The fees prescribed in
8 this subsection shall be deposited in the state treasury and
9 credited to the general fund of the state.

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PART 4A

MEDICARE SUPPLEMENT CERTIFICATES

12 SEC. 451. AS USED IN THIS PART:

13 (A) "APPLICANT" MEANS:

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

16 (*ii*) FOR A GROUP MEDICARE SUPPLEMENT CERTIFICATE, THE PRO17 POSED CERTIFICATE HOLDER.

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

21 (C) "CERTIFICATE FORM" MEANS THE FORM ON WHICH THE CERTIFI22 CATE 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.

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(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
3 1396u.

4 (F) "MEDICARE" MEANS TITLE XVIII OF THE SOCIAL SECURITY ACT,
5 CHAPTER 531, 49 STAT. 620, 42 U.S.C. 1395 TO 1395b, 1395b-2,
6 1395c TO 1395i, 1395i-2 TO 1395i-4, 1395j TO 1395t, 1395u TO
7 1395w-2, AND 1395w-4 TO 1395ccc.

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

13 COMMISSIONER.

(H) "MEDICARE SUPPLEMENT CERTIFICATE" MEANS A NONGROUP OR 14 15 GROUP CERTIFICATE THAT IS ADVERTISED, MARKETED, OR DESIGNED PRI-16 MARILY AS A SUPPLEMENT TO REIMBURSEMENTS UNDER MEDICARE FOR THE 17 HOSPITAL, MEDICAL, OR SURGICAL EXPENSES OF PERSONS ELIGIBLE FOR 18 MEDICARE AND MEDICARE SELECT CERTIFICATES UNDER SECTION 467. 19 MEDICARE SUPPLEMENT CERTIFICATE DOES NOT INCLUDE A CERTIFICATE OF 20 | OR MORE EMPLOYERS OR LABOR ORGANIZATIONS, OR OF THE TRUSTEES OF 21 A FUND ESTABLISHED BY 1 OR MORE EMPLOYERS OR LABOR ORGANIZATIONS, 22 OR BOTH, FOR EMPLOYEES OR FORMER EMPLOYEES, OR BOTH, OR FOR MEM-23 BERS OR FORMER MEMBERS, OR BOTH, OF THE LABOR ORGANIZATIONS. SEC. 452. (1) EXCEPT AS PROVIDED IN SUBSECTION (2), THIS 24 25 PART APPLIES TO A MEDICARE SUPPLEMENT CERTIFICATE DELIVERED, 26 ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE ON OR AFTER THE 27 EFFECTIVE DATE OF THIS PART.

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

4 SEC. 453. AS USED IN A MEDICARE SUPPLEMENT CERTIFICATE: 5 (A) THE DEFINITION OF "ACCIDENT", "ACCIDENTAL INJURY", OR 6 "ACCIDENTAL MEANS" SHALL NOT INCLUDE WORDS THAT ESTABLISH AN 7 ACCIDENTAL MEANS TEST OR USE WORDS SUCH AS "EXTERNAL, VIOLENT, 8 VISIBLE WOUNDS" OR SIMILAR WORDS OF DESCRIPTION OR 9 CHARACTERIZATION. THE DEFINITION MAY PROVIDE THAT INJURIES SHALL 10 NOT INCLUDE INJURIES FOR WHICH BENEFITS ARE PROVIDED OR AVAILABLE 11 UNDER ANY WORKER'S COMPENSATION, EMPLOYER'S LIABILITY OR SIMILAR 12 LAW, OR MOTOR VEHICLE NO-FAULT PLAN, UNLESS PROHIBITED BY LAW.

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

16 (C) "HOSPITAL" MAY BE DEFINED IN RELATION TO ITS STATUS,
17 FACILITIES, AND AVAILABLE SERVICES OR TO REFLECT ITS ACCREDIT18 ATION BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, BUT
19 NOT MORE RESTRICTIVELY THAN AS DEFINED IN MEDICARE.

20 (D) THE DEFINITION OF "MEDICARE ELIGIBLE EXPENSES" SHALL
21 MEAN HEALTH CARE EXPENSES OF THE KINDS COVERED BY MEDICARE, TO
22 THE EXTENT RECOGNIZED AS REASONABLE AND MEDICALLY NECESSARY BY
23 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

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INSTRUCTION, THEN THE USE OF THOSE TERMS REQUIRES THE HEALTH CARE
 CORPORATION TO RECOGNIZE THE SERVICES OF ANY INDIVIDUAL WHO QUAL IFIES 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.

6 (F) "PHYSICIAN" SHALL NOT BE DEFINED MORE RESTRICTIVELY THAN7 AS DEFINED IN MEDICARE.

8 (G) "SICKNESS" SHALL NOT BE DEFINED MORE RESTRICTIVELY THAN 9 TO MEAN ILLNESS OR DISEASE OF A COVERED PERSON THAT FIRST MANI-10 FESTS ITSELF AFTER THE EFFECTIVE DATE OF COVERAGE AND WHILE THE 11 COVERAGE IS IN FORCE. THE DEFINITION MAY BE FURTHER MODIFIED TO 12 EXCLUDE SICKNESSES OR DISEASES FOR WHICH BENEFITS ARE PROVIDED TO 13 THE MEMBER UNDER ANY WORKER'S COMPENSATION, OCCUPATIONAL DISEASE, 14 EMPLOYER'S LIABILITY, OR SIMILAR LAW.

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

17 SEC. 455. EVERY HEALTH CARE CORPORATION ISSUING A MEDICARE 18 SUPPLEMENT CERTIFICATE IN THIS STATE SHALL MAKE AVAILABLE A MEDI-19 CARE SUPPLEMENT CERTIFICATE THAT INCLUDES ONLY A BASIC CORE PACK-20 AGE OF BENEFITS TO EACH PROSPECTIVE MEMBER. A HEALTH CARE CORPO-21 RATION ISSUING A MEDICARE SUPPLEMENT CERTIFICATE IN THIS STATE 22 MAY MAKE AVAILABLE TO PROSPECTIVE MEMBERS BENEFITS PURSUANT TO 23 SECTION 459 THAT ARE IN ADDITION TO, BUT NOT INSTEAD OF, THE 24 BASIC CORE PACKAGE. THE BASIC CORE PACKAGE OF BENEFITS SHALL 25 INCLUDE ALL OF THE FOLLOWING:

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(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.

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

7 (C) UPON EXHAUSTION OF THE MEDICARE HOSPITAL INPATIENT COV-8 ERAGE INCLUDING THE LIFETIME RESERVE DAYS, COVERAGE OF THE MEDI-9 CARE PART A ELIGIBLE EXPENSES FOR HOSPITALIZATION PAID AT THE 10 DIAGNOSTIC RELATED GROUP DAY OUTLIER PER DIEM OR OTHER APPROPRI-11 ATE STANDARD OF PAYMENT, SUBJECT TO A LIFETIME MAXIMUM BENEFIT OF 12 AN ADDITIONAL 365 DAYS.

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

17 (E) COVERAGE FOR THE COINSURANCE AMOUNT OF MEDICARE ELIGIBLE
18 EXPENSES UNDER PART B REGARDLESS OF HOSPITAL CONFINEMENT, SUBJECT
19 TO THE MEDICARE PART B DEDUCTIBLE.

20 SEC. 457. EVERY HEALTH CARE CORPORATION ISSUING A MEDICARE 21 SUPPLEMENT CERTIFICATE IN THIS STATE SHALL MAKE AVAILABLE A MEDI-22 CARE SUPPLEMENT CERTIFICATE THAT INCLUDES THE BENEFITS PROVIDED 23 IN SECTION 461(5)(C).

24 SEC. 459. (1) IN ADDITION TO THE BASIC CORE PACKAGE OF 25 BENEFITS REQUIRED UNDER SECTION 455, THE FOLLOWING BENEFITS MAY 26 BE INCLUDED IN A MEDICARE SUPPLEMENT CERTIFICATE AND IF INCLUDED 27 SHALL CONFORM TO SECTION 461(5)(B) TO (J):

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

4 (B) SKILLED NURSING FACILITY CARE: COVERAGE FOR THE ACTUAL 5 BILLED CHARGES UP TO THE COINSURANCE AMOUNT FROM THE 21ST DAY 6 THROUGH THE 100TH DAY IN A MEDICARE BENEFIT PERIOD FOR POSTHOSPI-7 TAL SKILLED NURSING FACILITY CARE ELIGIBLE UNDER MEDICARE PART 8 A.

9 (C) MEDICARE PART B DEDUCTIBLE: COVERAGE FOR ALL OF THE 10 MEDICARE PART B DEDUCTIBLE AMOUNT PER CALENDAR YEAR REGARDLESS OF 11 HOSPITAL CONFINEMENT.

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

17 (E) ONE HUNDRED PERCENT OF THE MEDICARE PART B EXCESS
18 CHARGES: COVERAGE FOR ALL OF THE DIFFERENCE BETWEEN THE ACTUAL
19 MEDICARE PART B CHARGE AS BILLED, NOT TO EXCEED ANY CHARGE LIMI20 TATION ESTABLISHED BY MEDICARE OR STATE LAW, AND THE
21 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.

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(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 COV 5 ERED BY MEDICARE.

6 (H) MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN 7 COUNTRY: COVERAGE TO THE EXTENT NOT COVERED BY MEDICARE FOR 80% 8 OF THE BILLED CHARGES FOR MEDICARE-ELIGIBLE EXPENSES FOR MEDI-9 CALLY NECESSARY EMERGENCY HOSPITAL, PHYSICIAN, AND MEDICAL CARE 10 RECEIVED IN A FOREIGN COUNTRY, WHICH CARE WOULD HAVE BEEN COVERED 11 BY MEDICARE IF PROVIDED IN THE UNITED STATES AND WHICH CARE BEGAN 12 DURING THE FIRST 60 CONSECUTIVE DAYS OF EACH TRIP OUTSIDE THE 13 UNITED STATES, SUBJECT TO A CALENDAR YEAR DEDUCTIBLE OF \$250.00, 14 AND A LIFETIME MAXIMUM BENEFIT OF \$50,000.00. FOR PURPOSES OF 15 THIS BENEFIT, "EMERGENCY CARE" MEANS CARE NEEDED IMMEDIATELY 16 BECAUSE OF AN INJURY OR AN ILLNESS OF SUDDEN AND UNEXPECTED 17 ONSET.

18 (I) PREVENTIVE MEDICAL CARE BENEFIT: COVERAGE FOR THE FOL19 LOWING PREVENTIVE HEALTH SERVICES:

20 (i) AN ANNUAL CLINICAL PREVENTIVE MEDICAL HISTORY AND PHYSI21 CAL EXAMINATION THAT MAY INCLUDE TESTS AND SERVICES FROM
22 SUBPARAGRAPH (ii) AND PATIENT EDUCATION TO ADDRESS PREVENTIVE
23 HEALTH CARE MEASURES.

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

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

2 (B) MAMMOGRAM.

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3 (C) DIPSTICK URINALYSIS FOR HEMATURIA, BACTERIURIA, AND4 PROTEINURIA.

5 (D) PURE TONE, AIR ONLY, HEARING SCREENING TEST, ADMINIS6 TERED OR ORDERED BY A PHYSICIAN.

7 (E) SERUM CHOLESTEROL SCREENING EVERY 5 YEARS.

8 (F) THYROID FUNCTION TEST.

9 (G) DIABETES SCREENING.

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

13 (I) ANY OTHER TESTS OR PREVENTIVE MEASURES DETERMINED APPRO14 PRIATE 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
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 MEDI CARE APPROVED HOME CARE PLAN OF TREATMENT.

6 (*ii*) THE ACTUAL CHARGES FOR EACH VISIT UP TO A MAXIMUM REIM7 BURSEMENT OF \$40.00 PER VISIT.

8 (*iii*) ONE THOUSAND SIX HUNDRED DOLLARS PER CALENDAR YEAR.
9 (*iv*) SEVEN VISITS IN ANY 1 WEEK.

10 (ν) CARE FURNISHED ON A VISITING BASIS IN THE MEMBER'S 11 HOME.

12 (vi) SERVICES PROVIDED BY A CARE PROVIDER AS DEFINED IN THIS 13 SECTION.

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

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

20 (K) NEW OR INNOVATIVE BENEFITS: A HEALTH CARE CORPORATION
21 MAY, WITH THE PRIOR APPROVAL OF THE COMMISSIONER, OFFER NEW OR
22 INNOVATIVE BENEFITS IN ADDITION TO THE BENEFITS PROVIDED IN A
23 CERTIFICATE THAT OTHERWISE COMPLIES WITH THE APPLICABLE
24 STANDARDS. THESE BENEFITS MAY INCLUDE BENEFITS THAT ARE APPRO25 PRIATE TO MEDICARE SUPPLEMENT COVERAGE, NEW OR INNOVATIVE, NOT
26 OTHERWISE AVAILABLE, COST-EFFECTIVE, AND OFFERED IN A MANNER THAT

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

3 (2) REIMBURSEMENT FOR THE PREVENTIVE SCREENING TESTS AND
4 SERVICES UNDER SUBSECTION (1)(1)(ii) SHALL BE FOR THE ACTUAL
5 CHARGES UP TO 100% OF THE MEDICARE-APPROVED AMOUNT FOR EACH TEST
6 OR SERVICE, AS IF MEDICARE WERE TO COVER THE TEST OR SERVICE AS
7 IDENTIFIED IN THE AMERICAN MEDICAL ASSOCIATION CURRENT PROCEDURAL
8 TERMINOLOGY CODES, TO A MAXIMUM OF \$120.00 ANNUALLY UNDER THIS
9 BENEFIT. THIS BENEFIT SHALL NOT INCLUDE PAYMENT FOR ANY PROCE10 DURE COVERED BY MEDICARE.

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

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

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

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

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

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1 24-HOUR PERIOD OF SERVICES PROVIDED BY A CARE PROVIDER IS 12 VISIT.

3 SEC. 461. (1) A HEALTH CARE CORPORATION SHALL MAKE AVAIL-4 ABLE TO EACH PROSPECTIVE MEDICARE SUPPLEMENT CERTIFICATE HOLDER A 5 CERTIFICATE FORM CONTAINING ONLY THE BASIC CORE BENEFITS AS PRO-6 VIDED IN SECTION 455.

7 (2) GROUPS, PACKAGES, OR COMBINATIONS OF MEDICARE SUPPLEMENT
8 BENEFITS OTHER THAN THOSE LISTED IN THIS SECTION SHALL NOT BE
9 OFFERED FOR SALE IN THIS STATE EXCEPT AS MAY BE PERMITTED IN SEC10 TION 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.

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

22 (5) A MEDICARE SUPPLEMENT BENEFIT PLAN SHALL CONFORM TO 1 OF23 THE FOLLOWING:

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

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(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 SEC TION 459(1)(A).

5 (C) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN C SHALL 6 INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SEC-7 TION 455, THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACIL-8 ITY CARE, MEDICARE PART B DEDUCTIBLE, AND MEDICALLY NECESSARY 9 EMERGENCY CARE IN A FOREIGN COUNTRY AS DEFINED IN SECTION 10 459(1)(A), (B), (C), AND (H).

(D) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN D SHALL
12 INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SEC13 TION 455, THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACIL14 ITY CARE, MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUN15 TRY, AND THE AT-HOME RECOVERY BENEFIT AS DEFINED IN SECTION
16 459(1)(A), (B), (H), AND (J).

(E) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN E SHALL
18 INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SEC19 TION 455, THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACIL20 ITY CARE, MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUN21 TRY, AND PREVENTIVE MEDICAL CARE AS DEFINED IN SECTION 459(1)(A),
22 (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

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1 FOREIGN COUNTRY AS DEFINED IN SECTION 459(1)(A), (B), (C), (E), 2 AND (H).

3 (G) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN G SHALL
4 INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SEC5 TION 455, THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACIL6 ITY CARE, 80% OF THE MEDICARE PART B EXCESS CHARGES, MEDICALLY
7 NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY, AND THE AT-HOMÉ
8 RECOVERY BENEFIT AS DEFINED IN SECTION 459(1)(A), (B), (D), (H),
9 AND (J).

(H) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN H SHALL
11 INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SEC12 TION 455, THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACIL13 ITY CARE, BASIC OUTPATIENT PRESCRIPTION DRUG BENEFIT, AND MEDI14 CALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY AS DEFINED IN
15 SECTION 459(1)(A), (B), (F), AND (H).

(I) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN I SHALL
(I) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN I SHALL
INCLUDE ONLY THE FOLLOWING: THE CORE BENEFITS AS DEFINED IN SECITY 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,

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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).

4 SEC. 463. A HEALTH CARE CORPORATION THAT ISSUES A CERTIFI-5 CATE THAT PROVIDES DISABILITY COVERAGE TO A PERSON ELIGIBLE FOR 6 MEDICARE BY REASON OF AGE SHALL PROVIDE THE PROSPECTIVE CERTIFI-7 CATE HOLDER WITH A MEDICARE SUPPLEMENT BUYER'S GUIDE, WHICH SHALL 8 BE FURNISHED AT THE TIME OF APPLICATION, AND ACKNOWLEDGMENT OF 9 RECEIPT OF THE BUYER'S GUIDE SHALL BE OBTAINED BY THE HEALTH CARE 10 CORPORATION. HOWEVER, FOR DIRECT RESPONSE SOLICITATION CERTIFI-11 CATES, THE GUIDE SHALL BE FURNISHED WITH THE CERTIFICATE AND 12 ACKNOWLEDGMENT OF RECEIPT NEED NOT BE OBTAINED BY THE HEALTH CARE 13 CORPORATION.

14 SEC. 465. (1) A HEALTH CARE CORPORATION THAT OFFERS A MEDI-15 CARE SUPPLEMENT CERTIFICATE SHALL PROVIDE AN OUTLINE OF COVERAGE 16 TO THE APPLICANT AT THE TIME OF APPLICATION AND, EXCEPT FOR 17 DIRECT RESPONSE SOLICITATION CERTIFICATES, SHALL OBTAIN AN 18 ACKNOWLEDGMENT OF RECEIPT OF THE OUTLINE OF COVERAGE FROM THE 19 APPLICANT. THE OUTLINE OF COVERAGE PROVIDED TO APPLICANTS PURSU-20 ANT TO THIS SECTION SHALL CONSIST OF THE FOLLOWING 4 PARTS:

21 (A) A COVER PAGE.

22 (B) PREMIUM INFORMATION.

23 (C) DISCLOSURE PAGES.

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

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

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1 A BASIS THAT WOULD REQUIRE REVISION OF THE OUTLINE, A SUBSTITUTE 2 OUTLINE OF COVERAGE PROPERLY DESCRIBING THE CERTIFICATE SHALL BE 3 DELIVERED WITH THE CERTIFICATE AND CONTAIN THE FOLLOWING STATE-4 MENT, IN NO LESS THAN 12-POINT TYPE, IMMEDIATELY ABOVE THE COM-5 PANY NAME:

6 NOTICE: READ THIS OUTLINE OF COVERAGE CAREFULLY. IT IS NOT
7 IDENTICAL TO THE OUTLINE OF COVERAGE PROVIDED UPON APPLICA8 TION AND THE COVERAGE ORIGINALLY APPLIED FOR HAS NOT BEEN
9 ISSUED.

(3) AN OUTLINE OF COVERAGE UNDER SUBSECTION (1) OR (2) SHALL
11 BE IN THE LANGUAGE AND FORMAT PRESCRIBED IN THIS SECTION AND IN
12 NOT LESS THAN 12-POINT TYPE. THE A THROUGH J LETTER DESIGNATION
13 OF THE PLAN SHALL BE SHOWN ON THE COVER PAGE AND THE PLANS
14 OFFERED BY THE HEALTH CARE CORPORATION SHALL BE PROMINENTLY
15 IDENTIFIED. PREMIUM INFORMATION SHALL BE SHOWN ON THE COVER PAGE
16 OR IMMEDIATELY FOLLOWING THE COVER PAGE AND SHALL BE PROMINENTLY
17 DISPLAYED. THE PREMIUM AND METHOD OF PAYMENT SHALL BE STATED FOR
18 ALL PLANS THAT ARE OFFERED TO THE APPLICANT. ALL POSSIBLE PREMI19 UMS FOR THE APPLICANT SHALL BE ILLUSTRATED. THE FOLLOWING ITEMS
20 SHALL BE INCLUDED IN THE OUTLINE OF COVERAGE IN THE ORDER PRE21 SCRIBED BELOW AND IN SUBSTANTIALLY THE FOLLOWING FORM, AS
22 APPROVED BY THE COMMISSIONER:

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1 2 3 4 5 6	BENEFI MEDICARE SUPPLEMEN BENEFITS INCLUDED	T PLAN	(S) Rage c	MEDIC MEDICA [AN BE	ARE SU ARE SU INSERI SOLD I	PPLEME PPLEME LETT	Y 10 STA	RAGE RAGE-COV PLAN(S) NDARD PI	BEING OF	S CHART S	
7890123	"A". SOME PLANS M BASIC BENEFITS: IN HOSPITALIZATION: BENEFITS END. MEDICAL EXPENSES: BLOOD: FIRST THRE	CLUDED PART A PART	IN AL COINS B COIN	L PLAN URANCE SURANC	S. PLUS E (20%	COVER	AGE FOR		TIONAL DA		MEDICARI
4		A	В	C	D	E	F	G	H	I	JJ
	BASIC BENEFITS	X	x	x	x	x	X	X	x	x	x
3	SKILLED NURSING CO-INSURANCE			x	x	x	x	x I	x	x	x
	PART A DEDUCTIBLE		x	X	X	X	X	X	X	X	X
	PART B DEDUCTIBLE	1		X		1	x	1			X
	PART B EXCESS	1				1	X 100%	X 80%		X 100%	X 100%
	FOREIGN TRAVEL EMERGENCY			x	x	x	x	x	x	x	x
	AT-HOME RECOVERY	[I	X	1	1	X		X	X
	DRUGS							1	X \$1,250 LIMIT	X \$1,250 LIMIT	X \$3,000 LIMIT

PREMIUM INFORMATION

2 WE (INSERT HEALTH CARE CORPORATION'S NAME) CAN ONLY RAISE 3 YOUR PREMIUM IF WE RAISE THE PREMIUM FOR ALL CERTIFICATES LIKE 4 YOURS IN THIS STATE. (IF THE PREMIUM IS BASED ON THE INCREASING 5 AGE OF THE MEMBER, INCLUDE INFORMATION SPECIFYING WHEN PREMIUMS 6 WILL CHANGE).

7

DISCLOSURES

8 USE THIS OUTLINE TO COMPARE BENEFITS AND PREMIUMS AMONG POL9 ICIES, CERTIFICATES, AND CONTRACTS.

10

READ YOUR POLICY VERY CAREFULLY

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

15 RIGHT TO RETURN CERTIFICATE

16 IF YOU FIND THAT YOU ARE NOT SATISFIED WITH YOUR CERTIFI-17 CATE, YOU MAY RETURN IT TO (INSERT HEALTH CARE CORPORATION'S 18 ADDRESS). IF YOU SEND THE CERTIFICATE BACK TO US WITHIN 30 DAYS 19 AFTER YOU RECEIVE IT, WE WILL TREAT THE CERTIFICATE AS IF IT HAD 20 NEVER BEEN ISSUED AND RETURN ALL OF YOUR PAYMENTS.

21

CERTIFICATE REPLACEMENT

22 IF YOU ARE REPLACING ANOTHER HEALTH INSURANCE POLICY, CON23 TRACT, OR CERTIFICATE, DO NOT CANCEL IT UNTIL YOU HAVE ACTUALLY
24 RECEIVED YOUR NEW CERTIFICATE AND ARE SURE YOU WANT TO KEEP IT.

NOTICE

25

26 THIS CERTIFICATE MAY NOT FULLY COVER ALL OF YOUR MEDICAL27 COSTS.

[FOR AGENT ISSUED CERTIFICATES]

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

4 [FOR DIRECT RESPONSE ISSUED CERTIFICATES]

5 (INSERT HEALTH CARE CORPORATION'S NAME) IS NOT CONNECTED6 WITH MEDICARE.

7 THIS OUTLINE OF COVERAGE DOES NOT GIVE ALL THE DETAILS OF MEDI8 CARE COVERAGE. CONTACT YOUR LOCAL SOCIAL SECURITY OFFICE OR CON9 SULT "THE MEDICARE HANDBOOK" FOR MORE DETAILS.

10

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.]

17 REVIEW THE APPLICATION CAREFULLY BEFORE YOU SIGN IT. BE
18 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:

1

PLAN A

23

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

3 *A BENEFIT PERIOD BEGINS ON THE FIRST DAY YOU RECEIVE SERVICE AS AN INPA-4 TIENT IN A HOSPITAL AND ENDS AFTER YOU HAVE BEEN OUT OF THE HOSPITAL AND 5 HAVE NOT RECEIVED SKILLED CARE IN ANY OTHER FACILITY FOR 60 DAYS IN A 6 ROW. 7

8				
9	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
10 11				
	HOSPITALIZATION*			
	SEMIPRIVATE ROOM AND BOARD,			
	GENERAL NURSING AND MIS-			
	CELLANEOUS SERVICES AND SUPPLIES			
17	FIRST 60 DAYS	ALL BUT \$628	\$0	\$628 (PART A
18				DEDUCTIBLE)
19	61ST THRU 90TH DAY	ALL BUT \$157 A DAY	\$157 A DAY	\$0
20	91ST DAY AND AFTER:			
21 22	WHILE USING 60 LIFETIME RESERVE DAYS	ALL BUT \$314 A DAY	\$314 A DAY	\$0
23	ONCE LIFETIME RESERVE		+5+5	••
24	DAYS ARE USED:			
25	ADDITIONAL 365 DAYS	\$0	100% OF	\$0
26 27			MEDICARE	
28			EXPENSES	
29	BEYOND THE			
30	ADDITIONAL 365 DAYS	\$0	\$0	ALL COSTS
31 32		r	r	······
33	SKILLED NURSING FACILITY			
34	CARE*			
	YOU MUST MEET MEDICARE'S			
	REQUIREMENTS, INCLUDING HAVING BEEN IN A HOSPITAL	1		
	FOR AT LEAST 3 DAYS AND	1		
	ENTERED A MEDICARE-APPROVED			
40	FACILITY WITHIN 30 DAYS			
	AFTER LEAVING THE HOSPITAL	ALL APPROVED	1	
42 43	FIRST 20 DAYS	ALL APPROVED	\$0	\$0
43	21ST THRU 100TH DAY	ALL BUT \$78.50	\$0	UP TO \$78.50
45		A DAY		A DAY
46	101ST DAY AND AFTER	\$0	\$0	ALL COSTS
47 48		T	1	<u> </u>
49	BLOOD			
	FIRST 3 PINTS	\$0	3 PINTS	\$0
51	ADDITIONAL AMOUNTS	100%	\$0	\$0

1				
2				
3	HOSPICE CARE			
4	AVAILABLE AS LONG AS YOUR	ALL BUT VERY	S 0	BALANCE
5	DOCTOR CERTIFIES YOU ARE	LIMITED COINSURANCE	• -	
6	TERMINALLY ILL AND YOU	FOR OUTPATIENT		
7	ELECT TO RECEIVE THESE	DRUGS AND INPATIENT		
	SERVICES	RESPITE CARE		
9				

PLAN A

1 2

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

3 *ONCE YOU HAVE BEEN BILLED \$100 OF MEDICARE-APPROVED AMOUNTS FOR COVERED 4 SERVICES (WHICH ARE NOTED WITH AN ASTERISK), YOUR PART B DEDUCTIBLE WILL 5 HAVE BEEN MET FOR THE CALENDAR YEAR.

6				-
7 8 9	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
23456789	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			
2	APPROVED AMOUNTS*	\$0	\$0	\$100 (PART B DEDUCTIBLE)
24 25 26 27	REMAINDER OF MEDICARE APPROVED AMOUNTS PART B EXCESS CHARGES (ABOVE MEDICARE	80% (GENERALLY)	20% (GENERALLY)	\$0
28 29	APPROVED AMOUNTS)	\$0	\$0	ALL COSTS
0	BLOOD			
	FIRST 3 PINTS NEXT \$100 OF MEDICARE	\$0	ALL COSTS	\$0
84 85	APPROVED AMOUNTS*	\$0	\$0	\$100 (PART B DEDUCTIBLE)
86 87 88	REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	\$0
1	CLINICAL LABORATORY SERVICESBLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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(CONTINUED)

1		PARTS A & B		
2			+	·
3				
- 4	HOME HEALTH CARE			
5	MEDICARE APPROVED	×	ļ	j
6	SERVICES			
7	MEDICALLY NECESSARY			
8	SKILLED CARE SERVICES			
9	AND MEDICAL SUPPLIES	100%	\$0	\$0
10	DURABLE MEDICAL EQUIP-	{		
11	MENT	1		
12	FIRST \$100 OF MEDICARE			
13	APPROVED AMOUNTS*	\$0	\$0	\$100 (PART B
14			1	DEDUCTIBLE)
15	REMAINDER OF MEDICARE			
16	APPROVED AMOUNTS	80%	20%	\$0
17				·

PLAN B

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

3 *A BENEFIT PERIOD BEGINS ON THE FIRST DAY YOU RECEIVE SERVICE AS AN INPA-4 TIENT IN A HOSPITAL AND ENDS AFTER YOU HAVE BEEN OUT OF THE HOSPITAL AND 5 HAVE NOT RECEIVED SKILLED CARE IN ANY OTHER FACILITY FOR 60 DAYS IN A 6 ROW. 7

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8 9 10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
13 14 15	HOSPITALIZATION* SEMIPRIVATE ROOM AND BOARD, GENERAL NURSING AND MIS- CELLANEOUS SERVICES AND			20
16 17 18 19	SUPPLIES FIRST 60 DAYS	ALL BUT \$628	\$628 (PART A DEDUCTIBLE)	\$ 0
20 21 22	61ST THRU 90TH DAY 91ST DAY AND AFTER WHILE USING 60 LIFETIME	ALL BUT \$157 A DAY	\$157 A DAY	\$0
23 24 25	RESERVE DAYS ONCE LIFETIME RESERVE DAYS ARE USED:	ALL BUT \$314 A DAY	\$314 A DAY	\$0
26 27 28 29	ADDITIONAL 365 DAYS	\$0	100% OF MEDICARE ELIGIBLE EXPENSES	\$ 0
30 31 32	BEYOND THE ADDITIONAL 365 DAYS	\$0	\$0	ALL COSTS
35 36 37 38 39 40 41	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			
43 44 45 46 47 48	FIRST 20 DAYS 21ST THRU 100TH DAY 101ST DAY AND AFTER	ALL APPROVED AMOUNTS ALL BUT \$78.50 A DAY \$0	\$0 \$0 \$0	\$0 UP TO \$78.50 A DAY All COSTS
49 50 51	BLOOD FIRST 3 PINTS ADDITIONAL AMOUNTS	\$0 100%	3 PINTS \$0	\$0 \$0

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1				
2				
3	HOSPICE CARE			
4	AVAILABLE AS LONG AS YOUR	ALL BUT VERY	\$0	BALANCE
5	DOCTOR CERTIFIES YOU ARE	LIMITED COINSURANCE		
6	TERMINALLY ILL AND YOU	FOR OUTPATIENT		
7	ELECT TO RECEIVE THESE	DRUGS AND INPATIENT		
8	SERVICES	RESPITE CARE		
9		•		

PLAN B

2

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

3 *ONCE YOU HAVE BEEN BILLED \$100 OF MEDICARE-APPROVED AMOUNTS FOR COVERED 4 SERVICES (WHICH ARE NOTED WITH AN ASTERISK), YOUR PART B DEDUCTIBLE WILL 5 HAVE BEEN MET FOR THE CALENDAR YEAR.

6	······			
7 8 9	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
10 11 12 13 14 15 16 17 18 90 21 22	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
23 24 25 26 27 28 29	REMAINDER OF MEDICARE APPROVED AMOUNTS PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)	80% (GENERALLY) \$0	20% (GENERALLY) \$0	DEDUCTIBLE) \$0 ALL COSTS
30 31 32 33 3 <u>4</u> 35	BLOOD FIRST 3 PINTS NEXT \$100 OF MEDICARE APPROVED AMOUNTS* REMAINDER OF MEDICARE	\$0 \$0	ALL COSTS \$0	\$0 \$100 (PART B DEDUCTIBLE)
37 38 39 40 41	APPROVED AMOUNTS CLINICAL LABORATORY SERVICESBLOOD TESTS FOR DIAGNOSTIC SERVICES	80%	20% \$0	\$0 \$0

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1 2		PARTS A &	В	
3 4 5	HOME HEALTH CARE MEDICARE APPROVED	0+0		
6 7 8 9 10	SERVICES MEDICALLY NECESSARY SKILLED CARE SERVICES AND MEDICAL SUPPLIES DURABLE MEDICAL EQUIP-	100%	\$0	\$0
11 12 13	MENT FIRST \$100 OF MEDICARE APPROVED AMOUNTS*	\$0	\$0	\$100 (PART B
14 15 16	REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	DEDUCTIBLE) \$0

PLAN C

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

3 *A BENEFIT PERIOD BEGINS ON THE FIRST DAY YOU RECEIVE SERVICE AS AN INPA-4 TIENT IN A HOSPITAL AND ENDS AFTER YOU HAVE BEEN OUT OF THE HOSPITAL AND 5 HAVE NOT RECEIVED SKILLED CARE IN ANY OTHER FACILITY FOR 60 DAYS IN A 6 ROW. 7

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

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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

3 *ONCE YOU HAVE BEEN BILLED \$100 OF MEDICARE-APPROVED AMOUNTS FOR COVERED 4 SERVICES (WHICH ARE NOTED WITH AN ASTERISK), YOUR PART B DEDUCTIBLE WILL 5 HAVE BEEN MET FOR THE CALENDAR YEAR. 6

		·		
7 	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,			
1	DURABLE MEDICAL EQUIPMENT, FIRST \$100 OF MEDICARE			
2	APPROVED AMOUNTS*	\$0	\$100 (PART B	\$0
3	AFFROVED AMOUNIS"	\$0	DEDUCTIBLE)	30
4	REMAINDER OF MEDICARE		DEDUCTIBLE,	
5	APPROVED AMOUNTS	80% (GENERALLY)	20% (GENERALLY)	so
6	PART B EXCESS CHARGES			
7	(ABOVE MEDICARE			
8	APPROVED AMOUNTS)	\$0	\$0	ALL COSTS
9	······································	1.1.2		•
0				
	BLOOD			
	FIRST 3 PINTS	\$0	ALL COSTS	\$0
	NEXT \$100 OF MEDICARE			
4	APPROVED AMOUNTS*	\$0	\$100 (PART B	\$0
5			DEDUCTIBLE)	
	REMAINDER OF MEDICARE			
7	APPROVED AMOUNTS	80%	20%	\$0
3		<u></u>	1	i
9	CLINICAL LABORATORY			
_	SERVICESBLOOD TESTS	100%	\$0	\$0
	FOR DIAGNOSTIC SERVICES	1000		
3	LOK DINGHODIIC DEVAICED	1	I	1

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(CONTINUED)

1 2		PARTS A & B		
3 4 5 6	HOME HEALTH CARE MEDICARE APPROVED SERVICES			
7 8 9 10 11	MEDICALLY NECESSARY SKILLED CARE SERVICES AND MEDICAL SUPPLIES DURABLE MEDICAL EQUIP- MENT	100%	\$0	\$0
12 13 14	FIRST \$100 OF MEDICARE APPROVED AMOUNTS*	\$0	\$100 (PART B Deductible)	\$0
15 16 17	REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	\$0
18 19 20	OTHER BENER	FITSNOT COVERE	D BY MEDICARE	9
23 24 25 26 27	OUTSIDE THE USA FIRST \$250 EACH CALENDAR YEAR REMAINDER OF CHARGES	\$0 \$0	\$0 80% TO A LIFE- TIME MAXIMUM BENEFIT OF \$50,000	\$250 20% AND AMOUNTS OVER THE \$50,000 LIFETIME MAXIMUM

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PLAN D

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

3 *A BENEFIT PERIOD BEGINS ON THE FIRST DAY YOU RECEIVE SERVICE AS AN INPA-4 TIENT IN A HOSPITAL AND ENDS AFTER YOU HAVE BEEN OUT OF THE HOSPITAL AND 5 HAVE NOT RECEIVED SKILLED CARE IN ANY OTHER FACILITY FOR 60 DAYS IN A 6 ROW. 7

Å				
8 9 10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
13 14 15	HOSPITALIZATION* SEMIPRIVATE ROOM AND BOARD, GENERAL NURSING AND MIS- CELLANEOUS SERVICES AND			e s
16 17 18 19	SUPPLIES FIRST 60 DAYS	ALL BUT \$628	\$628 (PART A DEDUCATELE)	\$0
20 21 22	61ST THRU 90TH DAY 91ST DAY AND AFTER While USING 60 Lifetime	ALL BUT \$157 A DAY	DEDUCTIBLE) \$157 A DAY	\$ 0
23 24 25	RESERVE DAYS ONCE LIFETIME RESERVE DAYS ARE USED:	ALL BUT \$314 A DAY	\$314 A DAY	\$ 0
26 27 28 29	ADDITIONAL 365 DAYS	\$ 0	100% OF MEDICARE ELIGIBLE EXPENSES	\$0
30 - 31 - 32	BEYOND THE ADDITIONAL 365 DAYS	\$0	\$0	ALL COSTS
35 36 37 38 39 40 41 42 43 44 45 46 47	SKILLED NURSING FACILITY CARE* YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING HAVING BEEN IN A HOSPITAL FOR AT LEAST 3 DAYS AND ENTERED A MEDICARE-APPROVED FACILITY WITHIN 30 DAYS AFTER LEAVING THE HOSPITAL FIRST 20 DAYS 21ST THRU 100TH DAY	ALL APPROVED Amounts All But \$78.50 A DAY	\$0 UP TO \$78.50	\$0 \$0
48 49	101ST DAY AND AFTER	\$0	A DAY \$0	ALL COSTS

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

37

PLAN D

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

3 *ONCE YOU HAVE BEEN BILLED \$100 OF MEDICARE-APPROVED AMOUNTS FOR COVERED 4 SERVICES (WHICH ARE NOTED WITH AN ASTERISK), YOUR PART B DEDUCTIBLE WILL 5 HAVE BEEN MET FOR THE CALENDAR YEAR.

6				
7 8 9	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
10 11 12 13 14 15 16 17 18 19	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* REMAINDER OF MEDICARE APPROVED AMOUNTS PART B EXCESS CHARGES (ABOVE MEDICARE	\$0 80% (GENERALLY)	\$0 20% (GENERALLY)	\$100 (PART B DEDUCTIBLE) \$0
28 29	APPROVED AMOUNTS)	\$0	\$0	ALL COSTS
30 31 32 33 34 35 36 37 38	BLOOD FIRST 3 PINTS NEXT \$100 OF MEDICARE APPROVED AMOUNTS* REMAINDER OF MEDICARE APPROVED AMOUNTS	\$0 \$0 80%	ALL COSTS \$0 20%	\$0 \$100 (PART B DEDUCTIBLE) \$0
39 40 41 42 43	CLINICAL LABORATORY SERVICESBLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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(CONTINUED)

1 2	÷.	PARTS A & B		
	HOME HEALTH CARE			
_	MEDICARE APPROVED			
6 7	SERVICES			
8	MEDICALLY NECESSARY SKILLED CARE SERVICES			
ğ	AND MEDICAL SUPPLIES	100%	\$0	\$0
10	DURABLE MEDICAL EQUIP-	1008	ŞU	ŞU
11	MENT			
12	FIRST \$100 OF MEDICARE			
13	APPROVED AMOUNTS*	\$0	\$0	\$100 (PART B
14				DEDUCTIBLE)
15				
16	APPROVED AMOUNTS	80%	20%	\$0
	AT-HOME RECOVERY SERV-			
	VICESNOT COVERED BY			
	MEDICARE HOME CARE CERTI-			
	FIED BY YOUR DOCTOR, FOR		(i)	
	PERSONAL CARE DURING			
	RECOVERY FROM AN INJURY			
24	OR SICKNESS FOR WHICH			
25	MEDICARE APPROVED A HOME			
	CARE TREATMENT PLAN			
27	BENEFIT FOR EACH VISIT	\$0	ACTUAL CHARGES	
28			TO \$40 A VISIT	BALANCE
29]		}
30 31	COVERED (MUST BE RECEIVED WITHIN 8			
32	WEEKS OF LAST MEDI-			
33	CARE APPROVED VISIT)	\$0	UP TO THE NUM-	
34			BER OF MEDICARE	
35		1	APPROVED	
36			VISITS, NOT TO	
37			EXCEED 7 EACH	
38			WEEK	
39	CALENDAR YEAR MAXIMUM	\$0	\$1,600	1
40				

(CONTINUED)

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1 2	OTHER BENER	FITSNOT COVERED	D BY MEDICARE	
3 4	FOREIGN TRAVELNOT			
5	COVERED BY MEDICARE			
6	MEDICALLY NECESSARY EMER-			-
7	GENCY CARE SERVICES		121	
8	BEGINNING DURING THE		c .	
9	FIRST 60 DAYS OF EACH			
10	TRIP OUTSIDE THE USA		-	
11	FIRST \$250 EACH			
12	CALENDAR YEAR	\$0	\$0	\$250
13	REMAINDER OF CHARGES	\$0	80% TO A LIFE-	20% AND
14			TIME MAXIMUM	AMOUNTS OVER
15			BENEFIT OF	THE \$50,000
16		1	\$50,000	LIFETIME
17		İ	1	MAXIMUM
18				

1		PLAN E			
2	MEDICARE (PART A)H	HOSPITAL SERVICESP	ER BENEFIT P	ERIOD	
4 5	3 *A BENEFIT PERIOD BEGINS ON THE FIRST DAY YOU RECEIVE SERVICE AS AN INPA- 4 TIENT IN A HOSPITAL AND ENDS AFTER YOU HAVE BEEN OUT OF THE HOSPITAL AND 5 HAVE NOT RECEIVED SKILLED CARE IN ANY OTHER FACILITY FOR 60 DAYS IN A 6 ROW.				
8 9 10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY	
13 14 15	HOSPITALIZATION* SEMIPRIVATE ROOM AND BOARD, GENERAL NURSING AND MIS- CELLANEOUS SERVICES AND SUPPLIES FIRST 60 DAYS 61ST THRU 90TH DAY 91ST DAY AND AFTER WHILE USING 60 LIFETIME RESERVE DAYS ONCE LIFETIME RESERVE DAYS ARE USED: ADDITIONAL 365 DAYS	ALL BUT \$628 ALL BUT \$157 A DAY ALL BUT \$314 A DAY \$0	\$628 (PART A DEDUCTIBLE) \$157 A DAY \$314 A DAY 100% OF MEDICARE	\$0 \$0 \$0 \$0	
28 29 30 31	BEYOND THE Additional 365 days	\$0	ELIGIBLE EXPENSES	ALL COSTS	
35 36 37 38 39 40 41	SKILLED NURSING FACILITY CARE* YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING HAVING BEEN IN A HOSPITAL FOR AT LEAST 3 DAYS AND ENTERED A MEDICARE-APPROVED FACILITY WITHIN 30 DAYS AFTER LEAVING THE HOSPITAL FIRST 20 DAYS 21ST THRU 100TH DAY 101ST DAY AND AFTER	ALL APPROVED AMOUNTS ALL BUT \$78.50 A DAY \$0	\$0 UP TO \$78.50 A DAY \$0	\$0 \$0 All COSTS	

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1	- X -			
2 3	BLOOD			
4	FIRST 3 PINTS	\$0	3 PINTS	\$0
5	ADDITIONAL AMOUNTS	100%	\$0	\$0
6				•
7				
8	HOSPICE CARE			
9	AVAILABLE AS LONG AS YOUR	ALL BUT VERY	\$0	BALANCE
10	DOCTOR CERTIFIES YOU ARE	LIMITED COINSURANCE		
11	TERMINALLY ILL AND YOU	FOR OUTPATIENT		
12	ELECT TO RECEIVE THESE	DRUGS AND INPATIENT		
13	SERVICES	RESPITE CARE	1	
14			<u> </u>	

c

2 3	MEDICARE (PART B)-	-MEDICAL SERVICE	SPER CALENDAR	YEAR
5	*ONCE YOU HAVE BEEN BILLED S SERVICES (WHICH ARE NOTED W HAVE BEEN MET FOR THE CALEND	ITH AN ASTERISK)	-APPROVED AMOUNTS , YOUR PART B DEI	5 FOR COVERED DUCTIBLE WILL
8 9 10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
$\begin{array}{c} 11\\ 12\\ 13\\ 14\\ 15\\ 16\\ 17\\ 18\\ 9\\ 20\\ 22\\ 23\\ 24\\ 25\\ 27\\ 28\\ 27\\ 28\\ 28\\ 28\\ 28\\ 28\\ 28\\ 28\\ 28\\ 28\\ 28$	APPROVED AMOUNTS* REMAINDER OF MEDICARE APPROVED AMOUNTS PART B EXCESS CHARGES	\$0 80% (GENERALLY) \$0	\$0 20% (generally) \$0	\$100 (PART B DEDUCTIBLE) \$0 ALL COSTS
33 34 35 36 37	BLOOD FIRST 3 PINTS NEXT \$100 OF MEDICARE APPROVED AMOUNTS* REMAINDER OF MEDICARE APPROVED AMOUNTS	\$0 \$0 80%	ALL COSTS \$0 20%	\$0 \$100 (PART B DEDUCTIBLE) \$0
40 41 42	CLINICAL LABORATORY SERVICESBLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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(CONTINUED)

PLAN E

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		43		
1 2		PARTS A & B		
3 4 5 6 7 8	HOME HEALTH CARE MEDICARE APPROVED SERVICES MEDICALLY NECESSARY SKILLED CARE SERVICES			
9 10 11	AND MEDICAL SUPPLIES DURABLE MEDICAL EQUIP- MENT	100%	\$ 0	\$ 0
12 13 14 15	FIRST \$100 OF MEDICARE APPROVED AMOUNTS* REMAINDER OF MEDICARE	\$0	\$ 0	\$100 (PART B DEDUCTIBLE)
16 17	APPROVED AMOUNTS	80%	20%	\$0
18 19 20 21	OTHER BENEI	FITSNOT COVEREI	D BY MEDICARE	
25	FOREIGN TRAVEL NOT COVERED BY MEDICARE MEDICALLY NECESSARY EMER- GENCY CARE SERVICES BEGINNING DURING THE FIRST 60 DAYS OF EACH TRIP OUTSIDE THE USA FIRST \$250 EACH CALENDAR YEAR REMAINDER OF CHARGES	\$0 \$0	\$0 80% TO A LIFE- TIME MAXIMUM BENEFIT OF \$50,000	\$250 20% AND Amounts over The \$50,000 Lifetime Maximum
40 41 42 43 44 45 46 47 48 49 50 51	PREVENTIVE MEDICAL CARE BENEFITNOT COVERED BY MEDICARE ANNUAL PHYSICAL AND PREVEN- TIVE TESTS AND SERVICES SUCH AS: FECAL OCCULT BLOOD TEST, DIGITAL RECTAL EXAM, MAMMOGRAM, HEARING SCREENING, DIPSTICK URINALYSIS, DIABETES SCREENING, THYROID FUNC- TION TEST, INFLUENZA SHOT, TETANUS AND DIPHTHERIA BOOSTER AND EDUCATION,			

1 ADMINISTERED OR ORDERED 2 BY YOUR DOCTOR WHEN NOT 3 COVERED BY MEDICARE 4 FIRST \$120 EACH			
5 CALENDAR YEAR	\$0	\$120	\$0
6 ADDITIONAL CHARGES	\$0	\$0	ALL COSTS
7	••		•

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PLAN F

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

3 *A BENEFIT PERIOD BEGINS ON THE FIRST DAY YOU RECEIVE SERVICE AS AN INPA-4 TIENT IN A HOSPITAL AND ENDS AFTER YOU HAVE BEEN OUT OF THE HOSPITAL AND 5 HAVE NOT RECEIVED SKILLED CARE IN ANY OTHER FACILITY FOR 60 DAYS IN A 6 ROW.

		·····		······
8 9 10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
13 14 15	HOSPITALIZATION* SEMIPRIVATE ROOM AND BOARD, GENERAL NURSING AND MIS- CELLANEOUS SERVICES AND			
10 17 18 19	SUPPLIES FIRST 60 DAYS	ALL BUT \$628	\$628 (PART A DEDUCTIBLE)	\$ 0
20 21 22	61ST THRU 90TH DAY 91ST DAY AND AFTER WHILE USING 60 LIFETIME	ALL BUT \$157 A DAY	\$157 A DAY	\$0
23 24 25	ONCE LIFETIME RESERVE DAYS ARE USED:	ALL BUT \$314 A DAY	\$314 A DAY	\$ 0
26 27 28 29	ADDITIONAL 365 DAYS	\$ 0	100% OF MEDICARE ELIGIBLE EXPENSES	\$0
30 31 32	BEYOND THE Additional 365 days	\$0	\$0	ALL COSTS
35 36 37 38 39 40 41	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			
43 44 45 46 47 48	FIRST 20 DAYS 21ST THRU 100TH DAY	ALL APPROVED AMOUNTS ALL BUT \$78.50 A DAY	\$0 UP TO \$78.50 A DAY	\$0 \$0 ALL COSTS
49	101ST DAY AND AFTER	\$0	 \$ 0	LUD COLD

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BLOOD		÷ .	1
FIRST 3 PINTS	\$0	3 PINTS	\$0
5 ADDITIONAL AMOUNTS	100%	\$0	\$0
7			
B HOSPICE CARE			
AVAILABLE AS LONG AS YOUR	ALL BUT VERY	\$0	BALANCE
DOCTOR CERTIFIES YOU ARE	LIMITED COINSURANCE		
TERMINALLY ILL AND YOU	FOR OUTPATIENT		
2 ELECT TO RECEIVE THESE	DRUGS AND INPATIENT		
SERVICES	RESPITE CARE		

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PLAN F

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

3 *ONCE YOU HAVE BEEN BILLED \$100 OF MEDICARE-APPROVED AMOUNTS FOR COVERED 4 SERVICES (WHICH ARE NOTED WITH AN ASTERISK), YOUR PART B DEDUCTIBLE WILL 5 HAVE BEEN MET FOR THE CALENDAR YEAR. 6

	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDIC	AL EXPENSES			
	OUT OF THE HOSPITAL			-
	UTPATIENT HOSPITAL			
	MENT, SUCH AS PHYSI-			
	S SERVICES, INPATIENT			
	UTPATIENT MEDICAL AND			
	CAL SERVICES AND SUP-			
	, PHYSICAL AND SPEECH			
	PY, DIAGNOSTIC TESTS,			ļ
	LE MEDICAL EQUIPMENT,			1
	ST \$100 OF MEDICARE			
	PPROVED AMOUNTS*	\$0	\$100 (PART B	\$0
3	IIROVED MOONID	Ç.	DEDUCTIBLE)	• ••
	AINDER OF MEDICARE		,	
	PPROVED AMOUNTS	80% (GENERALLY)	20% (GENERALLY)	so
	T B EXCESS CHARGES			
	ABOVE MEDICARE			
	PPROVED AMOUNTS)	\$0	100%	\$0
9			• • • • • • • • • • • • • • • • • • • •	• • • • • • • • • • • • • • • • • • •
BLOOD				
	3 PINTS	\$0	ALL COSTS	\$0
	\$100 OF MEDICARE	¥.		
	ROVED AMOUNTS*	S 0	\$100 (PART B	S 0
5		+-	DEDUCTIBLE)	
	NDER OF MEDICARE			
	ROVED AMOUNTS	80%	20%	\$0
8				
· · · · ·				
D CLINI	CAL LABORATORY			
	CESBLOOD TESTS	100%	\$ 0	\$0
2 FOR D	IAGNOSTIC SERVICES		1	I

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(CONTINUED)

		40			
1 2		PARTS A & B			
3 4 5 6	HOME HEALTH CARE MEDICARE APPROVED SERVICES				
7 8 9 10 11	MEDICALLY NECESSARY SKILLED CARE SERVICES AND MEDICAL SUPPLIES DURABLE MEDICAL EQUIP- MENT	100%	\$0	\$0	
12 13 14 15	FIRST \$100 OF MEDICARE APPROVED AMOUNTS*	\$ 0	\$100 (PART B DEDUCTIBLE)	\$0	
15 16 17	REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	\$0	
18 19 20	OTHER BENEFITSNOT COVERED BY MEDICARE				
23 24 25 26 27	FOREIGN TRAVELNOT COVERED BY MEDICARE MEDICALLY NECESSARY EMER- GENCY CARE SERVICES BEGIN- NING DURING THE FIRST 60 DAYS OF EACH TRIP OUTSIDE THE USA FIRST \$250 EACH CALENDAR YEAR REMAINDER OF CHARGES	\$0 \$0	\$0 80% TO A LIFE- TIME MAXIMUM BENEFIT OF \$50,000	\$250 20% AND AMOUNTS OVER THE \$50,000 LIFETIME MAXIMUM	

PLAN G

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

3 *A BENEFIT PERIOD BEGINS ON THE FIRST DAY YOU RECEIVE SERVICE AS AN INPA-4 TIENT IN A HOSPITAL AND ENDS AFTER YOU HAVE BEEN OUT OF THE HOSPITAL AND 5 HAVE NOT RECEIVED SKILLED CARE IN ANY OTHER FACILITY FOR 60 DAYS IN A 6 ROW. 7

8 9 10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
13 14 15	HOSPITALIZATION* SEMIPRIVATE ROOM AND BOARD, GENERAL NURSING AND MIS- CELLANEOUS SERVICES AND SUPPLIES			
17 18 19	FIRST 60 DAYS	ALL BUT \$628	\$628 (PART A DEDUCTIBLE)	\$0
20 21 22	61ST THRU 90TH DAY 91ST DAY AND AFTER WHILE USING 60 LIFETIME	ALL BUT \$157 A DAY	\$157 A DAY	\$ 0
23 24 25	RESERVE DAYS ONCE LIFETIME RESERVE DAYS ARE USED:	ALL BUT \$314 A DAY	\$314 A DAY	\$0
26 27 28 29	ADDITIONAL 365 DAYS	\$0 	100% OF MEDICARE ELIGIBLE EXPENSES	\$0
30 31 32	BEYOND THE ADDITIONAL 365 DAYS	\$0	\$0	ALL COSTS
35 36 37 38 39 40 41 42 43 44 45 46 47	SKILLED NURSING FACILITY CARE* YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING HAVING BEEN IN A HOSPITAL FOR AT LEAST 3 DAYS AND ENTERED A MEDICARE-APPROVED FACILITY WITHIN 30 DAYS AFTER LEAVING THE HOSPITAL FIRST 20 DAYS 21ST THRU 100TH DAY	ALL APPROVED AMOUNTS ALL BUT \$78.50 A DAY	\$0 UP TO \$78.50 A DAY \$0	\$0 \$0 ALL COSTS
48	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

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PLAN G

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

3 *ONCE YOU HAVE BEEN BILLED \$100 OF MEDICARE-APPROVED AMOUNTS FOR COVERED 4 SERVICES (WHICH ARE NOTED WITH AN ASTERISK), YOUR PART B DEDUCTIBLE WILL 5 HAVE BEEN MET FOR THE CALENDAR YEAR.

6		······		
7 8 9	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
10 11 12 13 14 15 16 17 18 19	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* REMAINDER OF MEDICARE APPROVED AMOUNTS PART B EXCESS CHARGES (ABOVE MEDICARE	\$0 80% (GENERALLY)	\$0 20% (GENERALLY)	\$100 (PART B DEDUCTIBLE) \$0
28 29	APPROVED AMOUNTS)	\$0	80%	20%
32 33 34 35 36 37 38	BLOOD FIRST 3 PINTS NEXT \$100 OF MEDICARE APPROVED AMOUNTS* REMAINDER OF MEDICARE APPROVED AMOUNTS	\$0 \$0 80%	ALL COSTS \$0 20%	\$0 \$100 (PART B DEDUCTIBLE) \$0
41	CLINICAL LABORATORY SERVICESBLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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(CONTINUED)

1		PARTS A & B		
2				
3				
	HOME HEALTH CARE MEDICARE APPROVED			
_				
	SERVICES MEDICALLY NECESSARY			
7 8	SKILLED CARE SERVICES			
9	AND MEDICAL SUPPLIES	100%	\$ 0	\$0
10	DURABLE MEDICAL EQUIP-	1008	ΨŪ	ŞU
11	MENT			
12	FIRST \$100 OF MEDICARE			
13	APPROVED AMOUNTS*	\$0	\$0	\$100 (PART B
14				DEDUCTIBLE)
15	REMAINDER OF MEDICARE			
1 6	APPROVED AMOUNTS	80%	20%	\$ 0
	AT-HOME RECOVERY SERV-			
-	VICESNOT COVERED BY			
	MEDICARE			
	HOME CARE CERTI-			
	FIED BY YOUR DOCTOR, FOR PERSONAL CARE DURING			
	RECOVERY FROM AN INJURY			
	OR SICKNESS FOR WHICH			
	MEDICARE APPROVED A HOME			
	CARE TREATMENT PLAN			
27	BENEFIT FOR EACH VISIT	\$0	ACTUAL CHARGES	
28			TO \$40 A VISIT	BALANCE
29	NUMBER OF VISITS			
30	COVERED (MUST BE			
31	RECEIVED WITHIN 8			
32	WEEKS OF LAST MEDI-			
33	CARE APPROVED VISIT)	\$0	UP TO THE NUM- BER OF MEDICARE	
34 35			APPROVED	
36			VISITS, NOT TO	
37			EXCEED 7 EACH	
38			WEEK	
39	CALENDAR YEAR MAXIMUM	\$0	\$1,600	
40				. <u></u>

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(CONTINUED)

1 2	OTHER BENEL	FITSNOT COVERE	D BY MEDICARE	
7 8 9 10 11 12 13 14	FOREIGN TRAVELNOT COVERED BY MEDICARE MEDICALLY NECESSARY EMER- GENCY CARE SERVICES BEGINNING DURING THE FIRST 60 DAYS OF EACH TRIP OUTSIDE THE USA FIRST \$250 EACH CALENDAR YEAR REMAINDER OF CHARGES	\$0 \$0	\$0 80% TO A LIFE- TIME MAXIMUM DENDELT OF	\$250 20% AND AMOUNTS OVER
15 16 17 18			BENEFIT OF \$50,000	THE \$50,000 LIFETIME MAXIMUM

1	PLAN H						
2	MEDICARE (PART A)HOSPITAL SERVICESPER BENEFIT PER IOD						
4 5	*A BENEFIT PERIOD BEGINS ON THE FIRST DAY YOU RECEIVE SERVICE AS AN INPA- TIENT 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.						
8 9 10	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY			
13 14 15	HOSPITALIZATION* SEMIPRIVATE ROOM AND BOARD, GENERAL NURSING AND MIS- CELLANEOUS SERVICES AND CUDELIEC						
10 17 18 19	SUPPLIES FIRST 60 DAYS	ALL BUT \$628	\$628 (PART A DEDUCTIBLE)	\$O			
20 21 22	91ST DAY AND AFTER WHILE USING 60 LIFETIME	ALL BUT \$157 A DAY	\$157 A DAY	\$O			
23 24 25	RESERVE DAYS ONCE LIFETIME RESERVE DAYS ARE USED:	ALL BUT \$314 A DAY	\$314 A DAY	\$O			
26 27 28 29	ADDITIONAL 365 DAYS	\$0	100% OF MEDICARE ELIGIBLE EXPENSES	\$O			
30 31 32	BEYOND THE ADDITIONAL 365 DAYS	\$0	\$0	ALL COSTS			
35 36 37	SKILLED NURSING FACILITY CARE* YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING HAVING BEEN IN A HOSPITAL						
39 40 41	FOR AT LEAST 3 DAYS AND ENTERED A MEDICARE-APPROVED FACILITY WITHIN 30 DAYS AFTER LEAVING THE HOSPITAL FIRST 20 DAYS	ALL APPROVED					
44 45 46 47	21ST THRU 100TH DAY	AMOUNTS ALL BUT \$78.50 A DAY	\$0 UP TO \$78.50 A DAY	\$0 \$0			
48	101ST DAY AND AFTER	\$0	\$0	ALL COSTS			

1				
2 3 ∡	BLOOD FIRST 3 PINTS	\$0	3 PINTS	\$0
5	ADDITIONAL AMOUNTS	100%	\$0	\$0
6		T		
8	HOSPICE CARE			
9	AVAILABLE AS LONG AS YOUR	ALL BUT VERY	\$0	BALANCE
10	DOCTOR CERTIFIES YOU ARE	LIMITED COINSURANCE		
11	TERMINALLY ILL AND YOU	FOR OUTPATIENT		
12	ELECT TO RECEIVE THESE SERVICES	DRUGS AND INPATIENT RESPITE CARE		
14	SERVICES	RESPITE CARE	ł	1
		·····		

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8 9

10 11

SERVICES

13 IN OR OUT OF THE HOSPITAL

12 MEDICAL EXPENSES--

CIAN'S SERVICES, INPATIENT AND OUTPATIENT MEDICAL AND SURGICAL SERVICES AND SUP- PLIES, PHYSICAL AND SPEECH					
					2 m
APPROVED AMOUNTS*	\$ 0	•	\$ 0		\$100 (PART B DEDUCTIBLE)
	808	(GENERALLY)	20%	(GENERALLY)	\$0
•	A A				
APPROVED AMOUNTS)	\$ 0		 \$ 0		ALL COSTS
		<u></u>			
	ŞU		ALL	COSTS	\$0
APPROVED AMOUNTS*	\$ 0		\$0		\$100 (PART B Deductible)
APPROVED AMOUNTS	80%		20%		\$0
	1001	5	\$0		\$0
	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* REMAINDER OF MEDICARE APPROVED AMOUNTS PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS) BLOOD FIRST 3 PINTS NEXT \$100 OF MEDICARE APPROVED AMOUNTS* REMAINDER OF MEDICARE APPROVED AMOUNTS*	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*\$0REMAINDER OF MEDICARE APPROVED AMOUNTS PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)\$0BLOOD FIRST 3 PINTS NEXT \$100 OF MEDICARE APPROVED AMOUNTS*\$0BLOOD FIRST 3 PINTS NEXT \$100 OF MEDICARE APPROVED AMOUNTS*\$0CLINICAL LABORATORY SERVICESBLOOD TESTS1003	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*\$0REMAINDER OF MEDICARE APPROVED AMOUNTS PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)80% (GENERALLY)BLOOD FIRST 3 PINTS NEXT \$100 OF MEDICARE APPROVED AMOUNTS*\$0BLOOD 	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\$0REMAINDER OF MEDICARE APPROVED AMOUNTS PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)80% (GENERALLY) \$020%BLOOD FIRST 3 PINTS NEXT \$100 OF MEDICARE APPROVED AMOUNTS*\$0\$0BLOOD FIRST 3 PINTS NEXT \$100 OF MEDICARE APPROVED AMOUNTS*\$0\$0CLINICAL LABORATORY SERVICESBLOOD TESTS100%\$0	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\$0REMAINDER OF MEDICARE APPROVED AMOUNTS PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)80% (GENERALLY) \$020% (GENERALLY)BLOOD FIRST 3 PINTS NEXT \$100 OF MEDICARE APPROVED AMOUNTS*\$0\$0BLOOD FIRST 3 PINTS NEXT \$100 OF MEDICARE APPROVED AMOUNTS*\$0ALL COSTSREMAINDER OF MEDICARE APPROVED AMOUNTS*\$0\$0CLINICAL LABORATORY SERVICESBLOOD TESTS100%\$0

1

4 *ONCE YOU HAVE BEEN BILLED \$100 OF MEDICARE-APPROVED AMOUNTS FOR COVERED 5 SERVICES (WHICH ARE NOTED WITH AN ASTERISK), YOUR PART B DEDUCTIBLE WILL 6 HAVE BEEN MET FOR THE CALENDAR YEAR. 7

MEDICARE PAYS

PLAN PAYS

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

(CONTINUED)

YOU PAY

		57		
1 2		PARTS A & B		
3 4 5 6 7 8 9 10 11 12	HOME HEALTH CARE MEDICARE APPROVED SERVICES MEDICALLY NECESSARY SKILLED CARE SERVICES AND MEDICAL SUPPLIES DURABLE MEDICAL EQUIP- MENT	100%	\$0	\$0
3 4	FIRST \$100 OF MEDICARE APPROVED AMOUNTS*	\$0	\$0	\$100 (PART B DEDUCTIBLE)
15 16 17	REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	\$0
18 19 20 21	OTHER BENE	FITSNOT COVERE	D BY MEDICARE	
22 23 24 25 26 27 28	FOREIGN TRAVEL NOT COVERED BY MEDICARE MEDICALLY NECESSARY EMER- GENCY CARE SERVICES BEGINNING DURING THE FIRST 60 DAYS OF EACH TRIP			
	OUTSIDE THE USA			
30 31 32 33 34 35 36 37		\$0 \$0	\$0 80% TO A LIFE- TIME MAXIMUM BENEFIT OF \$50,000	\$250 20% AND AMOUNTS OVER THE \$50,000 LIFETIME MAXIMUM
30 331 333 334 335 335 335 335 335 335 335 335	OUTSIDE THE USA FIRST \$250 EACH CALENDAR YEAR REMAINDER OF CHARGES BASIC OUTPATIENT PRE- SCRIPTION DRUGSNOT COVERED BY MEDICARE	1.	80% TO A LIFE- TIME MAXIMUM BENEFIT OF	20% AND AMOUNTS OVER THE \$50,000 LIFETIME
30 31 33 33 33 33 33 33 33 33 33 33 33 33	OUTSIDE THE USA FIRST \$250 EACH CALENDAR YEAR REMAINDER OF CHARGES BASIC OUTPATIENT PRE- SCRIPTION DRUGSNOT	\$0 \$0	80% TO A LIFE- TIME MAXIMUM BENEFIT OF \$50,000 \$0	20% AND AMOUNTS OVER THE \$50,000 LIFETIME MAXIMUM \$250
40 41 42 43 44 45 46 47	OUTSIDE THE USA FIRST \$250 EACH CALENDAR YEAR REMAINDER OF CHARGES BASIC OUTPATIENT PRE- SCRIPTION DRUGSNOT COVERED BY MEDICARE FIRST \$250 EACH CALENDAR YEAR	\$0	80% TO A LIFE- TIME MAXIMUM BENEFIT OF \$50,000	20% AND AMOUNTS OVER THE \$50,000 LIFETIME MAXIMUM

PLAN I

1 2

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

3 *A BENEFIT PERIOD BEGINS ON THE FIRST DAY YOU RECEIVE SERVICE AS AN INPA-4 TIENT IN A HOSPITAL AND ENDS AFTER YOU HAVE BEEN OUT OF THE HOSPITAL AND 5 HAVE NOT RECEIVED SKILLED CARE IN ANY OTHER FACILITY FOR 60 DAYS IN A 6 ROW. 7

S PLAN PAYS	YOU PAY
	л¢.
\$628	\$0
(PART A DEDUCTIBLE)	
DAY \$157 A DAY	\$0
DAY \$314 A DAY	\$ 0
100% OF MEDICARE ELIGIBLE EXPENSES	\$0
	ALL COSTS
\$0 UP TO \$78.50 A DAY \$0	\$0 \$0 All COSTS
-	\$0 UP TO \$78.50

7

4	BLOOD FIRST 3 PINTS ADDITIONAL AMOUNTS	\$0 100%	3 PINTS \$0	\$0 \$0
9 10	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	\$O	BALANCE

1	PLAN I						
2	MEDICARE (PART B)MEDICAL SERVICESPER CALENDAR YEAR						
4	*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.						
7 8 9	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY			
12 13 14 15 16 17 18 19	APPROVED AMOUNTS* REMAINDER OF MEDICARE APPROVED AMOUNTS PART B EXCESS CHARGES	\$0 80% (GENERALLY) \$0	\$0 20% (GENERALLY) 100%	\$100 (PART B DEDUCTIBLE) \$0 \$0			
32 33 34 35 36 37 38	BLOOD FIRST 3 PINTS NEXT \$100 OF MEDICARE APPROVED AMOUNTS* REMAINDER OF MEDICARE APPROVED AMOUNTS	\$0 \$0 80%	ALL COSTS \$0 20%	\$0 \$100 (PART B DEDUCTIBLE) \$0			
41	CLINICAL LABORATORY SERVICESBLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0			

44

(CONTINUED)

1 2		PARTS A & B		
34	HOME HEALTH CARE			
5	MEDICARE APPROVED			
6	SERVICES			
7	MEDICALLY NECESSARY			
8	SKILLED CARE SERVICES			
9	AND MEDICAL SUPPLIES	100%	\$0	\$0
10	DURABLE MEDICAL EQUIP-			
11	MENT			
12	FIRST \$100 OF MEDICARE	••		
13	APPROVED AMOUNTS*	\$0	\$0	\$100 (PART B
14				DEDUCTIBLE)
15 16	REMAINDER OF MEDICARE	80%	20%	• •
	APPROVED AMOUNTS AT-HOME RECOVERY	008	208	\$0
18			1	
. –	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
26	BENEFIT FOR EACH VISIT	\$0	ACTUAL CHARGES	
27			TO \$40 A VISIT	
28	NUMBER OF VISITS COV-	\$0	UP TO THE NUM-	
29	ERED (MUST BE RECEIVED		BER OF MEDICARE	
30	WITHIN 8 WEEKS OF LAST	}	APPROVED	}
31	MEDICARE APPROVED		VISITS, NOT TO	
32	VISIT)		EXCEED 7 EACH	
33			WEEK	
34	CALENDAR YEAR MAXIMUM	\$0	\$1,600	l
35	·			

(CONTINUED)

The second second

1 2	OTHER BENEI	FITSNOT (COVEREI	BY MEDICARE	
3	5 (ž				
4	FOREIGN TRAVELNOT				
5	COVERED BY MEDICARE				
6	MEDICALLY NECESSARY EMER-				
-	GENCY CARE SERVICES BEGIN-				
8	NING DURING THE FIRST 60				
	DAYS OF EACH TRIP OUTSIDE				
	THE USA				
11	FIRST \$250 EACH CALEN-	so		\$0	\$2 50
12	DAR YEAR	7 -		· · ·	+100
13	REMAINDER OF CHARGES*	\$0		80% TO A LIFE-	20% AND
14		,		TIME MAXIMUM	AMOUNTS OVER
15				BENEFIT OF	THE \$50,000
16				\$50,000	LIFETIME
17					MAXIMUM
18		4			
19		1			
20	BASIC OUTPATIENT PRE-				
21	SCRIPTION DRUGSNOT				
	COVERED BY MEDICARE				
	FIRST \$250 EACH CALENDAR	\$0		\$0	\$250
	YEAR				· ·
	NEXT \$2,500 EACH CALENDAR	\$0		50%\$1,250	50%
	YEAR			CALENDAR YEAR	
27				MAXIMUM	
28				BENEFIT	
	OVER \$2,500 EACH CALENDAR	\$0		\$0	ALL COSTS
	YEAR	I		l	
31					

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PLAN J

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

3 *A BENEFIT PERIOD BEGINS ON THE FIRST DAY YOU RECEIVE SERVICE AS AN INPA-4 TIENT IN A HOSPITAL AND ENDS AFTER YOU HAVE BEEN OUT OF THE HOSPITAL AND 5 HAVE NOT RECEIVED SKILLED CARE IN ANY OTHER FACILITY FOR 60 DAYS IN A 6 ROW. 7

8 9	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
13 14 15 16 17 18 20 21 22 23 24 25 26 27 8 29 31	HOSPITALIZATION* SEMIPRIVATE ROOM AND BOARD, GENERAL NURSING AND MIS- CELLANEOUS SERVICES AND SUPPLIES FIRST 60 DAYS 61ST THRU 90TH DAY 91ST DAY AND AFTER WHILE USING 60 LIFETIME RESERVE DAYS ONCE LIFETIME RESERVE DAYS ARE USED: ADDITIONAL 365 DAYS BEYOND THE ADDITIONAL 365 DAYS	ALL BUT \$628 ALL BUT \$157 A DAY ALL BUT \$314 A DAY \$0	\$628 (PART A DEDUCTIBLE) \$157 A DAY \$314 A DAY 100% OF MEDICARE ELIGIBLE EXPENSES \$0	\$0 \$0 \$0 \$0 ALL COSTS
36 37 38 39	SKILLED NURSING FACILITY CARE* YOU MUST MEET MEDICARE'S REQUIREMENTS, INCLUDING HAVING BEEN IN A HOSPITAL FOR AT LEAST 3 DAYS AND ENTERED A MEDICARE-APPROVED FACILITY WITHIN 30 DAYS AFTER LEAVING THE HOSPITAL FIRST 20 DAYS 21ST THRU 100TH DAY 101ST DAY AND AFTER	ALL APPROVED AMOUNTS ALL BUT \$78.50 A DAY \$0	\$0 UP TO \$78.50 A DAY \$0	\$0 \$0 ALL COSTS

a de la companya de En esta de la companya
	BLOOD FIRST 3 PINTS ADDITIONAL AMOUNTS	\$0 100%	3 PINTS \$0	\$0 \$0
9 10 11 12	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

65

2 MEDIC

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

3 *ONCE YOU HAVE BEEN BILLED \$100 OF MEDICARE-APPROVED AMOUNTS FOR COVERED 4 SERVICES (WHICH ARE NOTED WITH AN ASTERISK), YOUR PART B DEDUCTIBLE WILL 5 HAVE BEEN MET FOR THE CALENDAR YEAR. 6

0				
7 8 9	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
10 11 12 13 14 15 16 17 18 19	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* REMAINDER OF MEDICARE APPROVED AMOUNTS PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)	\$0 80% (GENERALLY) \$0	\$100 (PART B DEDUCTIBLE) 20% (GENERALLY) 100%	\$0 \$0 \$0
30				
32	BLOOD FIRST 3 PINTS NEXT \$100 OF MEDICARE	\$0	ALL COSTS	\$0
34 35	APPROVED AMOUNTS*	\$0	\$100 (PART B DEDUCTIBLE)	\$0
	REMAINDER OF MEDICARE APPROVED AMOUNTS	80%	20%	\$0
39 40 41	CLINICAL LABORATORY SERVICESBLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

44

(CONTINUED)

1 2		PARTS A & B		
3 ∡	HOME HEALTH CARE			
5	MEDICARE APPROVED			
6	SERVICES			
7	MEDICALLY NECESSARY			
8	SKILLED CARE SERVICES			
9	AND MEDICAL SUPPLIES	100%	\$0	\$0
10	DURABLE MEDICAL EQUIP-	- 31 -		
11	MENT			
12	FIRST \$100 OF MEDICARE			
13	APPROVED AMOUNTS*	\$0	\$100 (PART B	\$O
14			DEDUCTIBLE)	-
15	REMAINDER OF MEDICARE			
16	APPROVED AMOUNTS	80%	20%	\$ O
	AT-HOME RECOVERY			
	SERVICESNOT COVERED			
	BY MEDICARE			
	HOME CARE CERTIFIED BY			
	YOUR DOCTOR, FOR PERSONAL			
	CARE BEGINNING DURING			
	RECOVERY FROM AN INJURY OR	40		
	SICKNESS FOR WHICH MEDICARE		}	
	APPROVED A HOME CARE TREAT-			1
	MENT PLAN BENEFIT FOR EACH VISIT	\$0	ACTUAL CHARGES	BALANCE
27 28	-BENEFIT FOR EACH VISIT	ŞU	TO \$40 A VISIT	BHUMMED
20 29	NUMBER OF VISITS COV-	so	UP TO THE NUM-	
30	ERED (MUST BE RECEIVED		BER OF MEDICARE	
31	WITHIN 8 WEEKS OF LAST		APPROVED	
32	MEDICARE APPROVED		VISITS, NOT TO	
33	VISIT)		EXCEED 7 EACH	÷
34	,		WEEK	
35	CALENDAR YEAR MAXIMUM	\$0	\$1,600	
36		• •	••••	

(CONTINUED)

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1 2	OTHER BENER	TITSNOT COVERED	BY MEDICARE	a.
3 4 5 6 7 8 9	FOREIGN TRAVELNOT COVERED BY MEDICARE MEDICALLY NECESSARY EMER- GENCY CARE SERVICES BEGIN- NING DURING THE FIRST 60 DAYS OF EACH TRIP OUTSIDE THE USA FIRST \$250 EACH CALEN- DAR YEAR REMAINDER OF CHARGES	\$0 \$0	\$0 80% TO A LIFE- TIME MAXIMUM BENEFIT OF \$50,000	\$250 20% AND AMOUNTS OVER THE \$50,000 LIFETIME MAXIMUM
19 20 21	EXTENDED OUTPATIENT PRE- SCRIPTION DRUGSNOT COVERED BY MEDICARE FIRST \$250 EACH CALENDAR	\$0	\$0	\$250
24 25 26 27	YEAR NEXT \$6,000 EACH CALENDAR YEAR		50%\$3,000 Calendar year Maximum	50%
28 29 30 31	OVER \$6,000 EACH CALENDAR YEAR	\$0	BENEFIT \$0	ALL COSTS
34 35 36 37 38 39 40 41 42 43 44 45 46 47	PREVENTIVE MEDICAL CARE BENEFITNOT COVERED BY MEDICARE ANNUAL PHYSICAL AND PRE- VENTIVE TESTS AND SERVICES SUCH AS: FECAL OCCULT BLOOD TEST, DIGITAL RECTAL EXAM, MAMMOGRAM, HEARING SCREENING, DIPSTICK URINALYSIS, DIABETES SCREENING, THYROID FUNC- TION 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
52 53	ADDITIONAL CHARGES	\$0	\$0	ALL COSTS

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

3 (2) AS USED IN THIS SECTION:

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

7 (B) "GRIEVANCE" MEANS A DISSATISFACTION EXPRESSED IN WRITING 8 BY AN INDIVIDUAL COVERED UNDER A MEDICARE SELECT CERTIFICATE WITH 9 THE ADMINISTRATION, CLAIMS PRACTICES, OR PROVISION OF SERVICES 10 CONCERNING A MEDICARE SELECT HEALTH CARE CORPORATION OR ITS NET-11 WORK PROVIDERS.

12 (C) "MEDICARE SELECT HEALTH CARE CORPORATION" MEANS A HEALTH 13 CARE CORPORATION OFFERING, OR SEEKING TO OFFER, A MEDICARE SELECT 14 CERTIFICATE.

15 (D) "MEDICARE SELECT CERTIFICATE" MEANS A MEDICARE SUPPLE-16 MENT CERTIFICATE THAT CONTAINS RESTRICTED NETWORK PROVISIONS.

17 (E) "NETWORK PROVIDER" MEANS A PROVIDER OF HEALTH CARE, OR A
18 GROUP OF PROVIDERS OF HEALTH CARE, THAT HAS ENTERED INTO A WRIT19 TEN AGREEMENT WITH THE HEALTH CARE CORPORATION TO PROVIDE BENE20 FITS UNDER A MEDICARE SELECT CERTIFICATE.

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

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

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

4 (4) THE COMMISSIONER MAY AUTHORIZE A HEALTH CARE CORPORATION 5 TO OFFER A MEDICARE SELECT CERTIFICATE, PURSUANT TO THIS SECTION 6 AND SECTION 1882 OF PART C OF TITLE XVIII OF THE SOCIAL SECURITY 7 ACT, CHAPTER 531, 49 STAT. 620, 42 U.S.C. 1395ss, IF THE COMMIS-8 SIONER FINDS THAT THE HEALTH CARE CORPORATION HAS SATISFIED ALL 9 NECESSARY REQUIREMENTS.

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

13 (6) A MEDICARE SELECT HEALTH CARE CORPORATION SHALL FILE A
14 PROPOSED PLAN OF OPERATION WITH THE COMMISSIONER IN A FORMAT PRE15 SCRIBED BY THE COMMISSIONER. THE PLAN OF OPERATION SHALL CONTAIN
16 AT LEAST THE FOLLOWING INFORMATION:

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

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

26 (*ii*) THAT THE NUMBER OF NETWORK PROVIDERS IN THE SERVICE
27 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.

4 (*iii*) THAT THERE ARE WRITTEN AGREEMENTS WITH NETWORK PROVID5 ERS DESCRIBING SPECIFIC RESPONSIBILITIES.

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

8 (ν) THAT IN THE CASE OF COVERED SERVICES THAT ARE SUBJECT TO
9 A RESTRICTED NETWORK PROVISION AND ARE PROVIDED ON A PREPAID
10 BASIS, THERE ARE WRITTEN AGREEMENTS WITH NETWORK PROVIDERS PRO11 HIBITING SUCH PROVIDERS FROM BILLING OR OTHERWISE SEEKING REIM12 BURSEMENT FROM OR RECOURSE AGAINST ANY INDIVIDUAL COVERED UNDER A
13 MEDICARE SELECT CERTIFICATE. THIS SUBPARAGRAPH DOES NOT APPLY TO
14 SUPPLEMENTAL CHARGES OR COINSURANCE AMOUNTS AS STATED IN THE
15 MEDICARE SELECT CERTIFICATE.

16 (B) A STATEMENT OR MAP PROVIDING A CLEAR DESCRIPTION OF THE 17 SERVICE AREA.

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

19 (D) A DESCRIPTION OF THE QUALITY ASSURANCE PROGRAM, INCLUD-20 ING ALL OF THE FOLLOWING:

21 (*i*) THE FORMAL ORGANIZATIONAL STRUCTURE.

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

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

1 (E) A LIST AND DESCRIPTION, BY SPECIALTY, OF THE NETWORK 2 PROVIDERS.

3 (F) COPIES OF THE WRITTEN INFORMATION PROPOSED TO BE USED BY 4 THE HEALTH CARE CORPORATION TO COMPLY WITH SUBSECTION (10).

5 (G) ANY OTHER INFORMATION REQUESTED BY THE COMMISSIONER.

6 (7) A MEDICARE SELECT HEALTH CARE CORPORATION SHALL FILE ANY 7 PROPOSED CHANGES TO THE PLAN OF OPERATION, EXCEPT FOR CHANGES TO 8 THE LIST OF NETWORK PROVIDERS, WITH THE COMMISSIONER PRIOR TO 9 IMPLEMENTING ANY CHANGES. AN UPDATED LIST OF NETWORK PROVIDERS 10 SHALL BE FILED WITH THE COMMISSIONER AT LEAST QUARTERLY. CHANGES 11 SHALL BE CONSIDERED APPROVED BY THE COMMISSIONER AFTER 30 DAYS 12 UNLESS SPECIFICALLY DISAPPROVED.

13 (8) A MEDICARE SELECT CERTIFICATE SHALL NOT RESTRICT PAYMENT
14 FOR COVERED SERVICES PROVIDED BY NONNETWORK PROVIDERS IF THE
15 SERVICES ARE FOR SYMPTOMS REQUIRING EMERGENCY CARE OR ARE IMMEDI16 ATELY REQUIRED FOR AN UNFORESEEN ILLNESS, INJURY, OR A CONDITION
17 AND IT IS NOT REASONABLE TO OBTAIN SUCH SERVICES THROUGH A NET18 WORK PROVIDER.

19 (9) A MEDICARE SELECT CERTIFICATE SHALL PROVIDE PAYMENT FOR
20 FULL COVERAGE UNDER THE CERTIFICATE FOR COVERED SERVICES THAT ARE
21 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:

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

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

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

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

15 (E) A DESCRIPTION OF LIMITATIONS ON REFERRALS TO RESTRICTED 16 NETWORK PROVIDERS AND TO OTHER PROVIDERS.

17 (F) A DESCRIPTION OF THE CERTIFICATE HOLDER'S RIGHTS TO PUR18 CHASE ANY OTHER MEDICARE SUPPLEMENT CERTIFICATE OTHERWISE OFFERED
19 BY THE HEALTH CARE CORPORATION.

(G) A DESCRIPTION OF THE MEDICARE SELECT HEALTH CARE
(G) A DESCRIPTION OF THE MEDICARE SELECT HEALTH CARE
(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.

1 (12) A MEDICARE SELECT HEALTH CARE CORPORATION SHALL HAVE 2 AND USE PROCEDURES FOR HEARING COMPLAINTS AND RESOLVING WRITTEN 3 GRIEVANCES FROM SUBSCRIBERS. THE PROCEDURES SHALL BE AIMED AT 4 MUTUAL AGREEMENT FOR SETTLEMENT AND MAY INCLUDE ARBITRATION 5 PROCEDURES. THE GRIEVANCE PROCEDURE SHALL BE DESCRIBED IN THE 6 CERTIFICATE AND IN THE OUTLINE OF COVERAGE. AT THE TIME THE CER-7 TIFICATE IS ISSUED, THE HEALTH CARE CORPORATION SHALL PROVIDE 8 DETAILED INFORMATION TO THE CERTIFICATE HOLDER DESCRIBING HOW A 9 GRIEVANCE MAY BE REGISTERED WITH THE HEALTH CARE CORPORATION. 10 GRIEVANCES SHALL BE CONSIDERED IN A TIMELY MANNER AND SHALL BE 11 TRANSMITTED TO APPROPRIATE DECISION-MAKERS WHO HAVE AUTHORITY TO 12 FULLY INVESTIGATE THE ISSUE AND TAKE CORRECTIVE ACTION. TF A 13 GRIEVANCE IS FOUND TO BE VALID, CORRECTIVE ACTION SHALL BE TAKEN 14 PROMPTLY. ALL CONCERNED PARTIES SHALL BE NOTIFIED ABOUT THE 15 RESULTS OF A GRIEVANCE. THE HEALTH CARE CORPORATION SHALL REPORT 16 NO LATER THAN EACH MARCH 31 TO THE COMMISSIONER REGARDING ITS 17 GRIEVANCE PROCEDURE. THE REPORT SHALL BE IN A FORMAT PRESCRIBED 18 BY THE COMMISSIONER AND SHALL CONTAIN THE NUMBER OF GRIEVANCES 19 FILED IN THE PAST YEAR AND A SUMMARY OF THE SUBJECT, NATURE, AND **20** RESOLUTION OF THOSE GRIEVANCES.

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

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

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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 BEN EFITS 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.

16 (15) MEDICARE SELECT CERTIFICATES SHALL PROVIDE FOR CONTINU-17 ATION OF COVERAGE IF THE SECRETARY OF HEALTH AND HUMAN SERVICES 18 DETERMINES THAT MEDICARE SELECT CERTIFICATES ISSUED PURSUANT TO 19 THIS SECTION SHOULD BE DISCONTINUED DUE TO EITHER THE FAILURE OF 20 THE MEDICARE SELECT PROGRAM TO BE REAUTHORIZED UNDER LAW OR ITS 21 SUBSTANTIAL AMENDMENT. EACH MEDICARE SELECT HEALTH CARE CORPORA-22 TION SHALL MAKE AVAILABLE TO EACH MEMBER COVERED UNDER A MEDICARE 23 SELECT CERTIFICATE THE OPPORTUNITY TO PURCHASE ANY MEDICARE SUP-24 PLEMENT CERTIFICATE OFFERED BY THE HEALTH CARE CORPORATION THAT 25 HAS COMPARABLE OR LESSER BENEFITS AND THAT DOES NOT CONTAIN A 26 RESTRICTED NETWORK PROVISION. THE ISSUER SHALL MAKE THE 27 CERTIFICATES AVAILABLE WITHOUT REQUIRING EVIDENCE OF

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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 PRE SCRIPTION DRUGS, COVERAGE FOR AT-HOME RECOVERY SERVICE OR COVER AGE FOR PART B EXCESS CHARGES.

9 (16) A MEDICARE SELECT HEALTH CARE CORPORATION SHALL COMPLY 10 WITH REASONABLE REQUESTS FOR DATA MADE BY STATE OR FEDERAL AGEN-11 CIES, INCLUDING THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN 12 SERVICES, FOR THE PURPOSES OF EVALUATING THE MEDICARE SELECT 13 PROGRAM.

14 SEC. 469. (1) A CERTIFICATE SHALL NOT BE TITLED, ADVER15 TISED, SOLICITED, OR ISSUED FOR DELIVERY IN THIS STATE AS A MEDI16 CARE SUPPLEMENT CERTIFICATE IF THE CERTIFICATE DOES NOT MEET THE
17 MINIMUM STANDARDS PRESCRIBED IN THIS SECTION. THESE MINIMUM
18 STANDARDS ARE IN ADDITION TO ALL OTHER REQUIREMENTS OF THIS
19 PART.

20 (2) THE FOLLOWING STANDARDS APPLY TO MEDICARE SUPPLEMENT
 21 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

1 GIVEN OR TREATMENT WAS RECOMMENDED BY OR RECEIVED FROM A 2 PHYSICIAN WITHIN 6 MONTHS BEFORE THE EFFECTIVE DATE OF COVERAGE.

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

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

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

(E) TERMINATION OF A MEDICARE SUPPLEMENT CERTIFICATE SHALL
16 NOT REDUCE OR LIMIT THE PAYMENT OF BENEFITS FOR ANY CONTINUOUS
17 LOSS THAT COMMENCED WHILE THE CERTIFICATE WAS IN FORCE, BUT THE
18 EXTENSION OF BENEFITS BEYOND THE PERIOD DURING WHICH THE CERTIFI19 CATE WAS IN FORCE MAY BE PREDICATED UPON THE CONTINUOUS TOTAL
20 DISABILITY OF THE MEMBER, LIMITED TO THE DURATION OF THE CERTIFI21 CATE BENEFIT PERIOD, IF ANY, OR PAYMENT OF THE MAXIMUM BENEFITS.
22 (F) A MEDICARE SUPPLEMENT CERTIFICATE SHALL NOT PROVIDE FOR
23 TERMINATION OF COVERAGE OF A SPOUSE SOLELY BECAUSE OF THE OCCUR24 RENCE OF AN EVENT SPECIFIED FOR TERMINATION OF COVERAGE OF THE
25 MEMBER, OTHER THAN THE NONPAYMENT OF PREMIUM.

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

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1 THE REQUEST OF THE CERTIFICATE HOLDER FOR A PERIOD NOT TO EXCEED 2 24 MONTHS IN WHICH THE CERTIFICATE HOLDER HAS APPLIED FOR AND IS 3 DETERMINED TO BE ENTITLED TO MEDICAL ASSISTANCE UNDER MEDICAID. 4 BUT ONLY IF THE CERTIFICATE HOLDER NOTIFIES THE HEALTH CARE COR-5 PORATION OF SUCH ASSISTANCE WITHIN 90 DAYS AFTER THE DATE THE 6 INDIVIDUAL BECOMES ENTITLED TO THE ASSISTANCE. UPON RECEIPT OF 7 TIMELY NOTICE, THE HEALTH CARE CORPORATION SHALL RETURN TO THE 8 CERTIFICATE HOLDER THAT PORTION OF THE PREMIUM ATTRIBUTABLE TO 9 THE PERIOD OF MEDICAID ELIGIBILITY, SUBJECT TO ADJUSTMENT FOR 10 PAID CLAIMS. IF A SUSPENSION OCCURS AND IF THE CERTIFICATE 11 HOLDER LOSES ENTITLEMENT TO MEDICAL ASSISTANCE UNDER MEDICAID. 12 THE CERTIFICATE SHALL BE AUTOMATICALLY REINSTITUTED EFFECTIVE AS 13 OF THE DATE OF TERMINATION OF THE ASSISTANCE IF THE CERTIFICATE 14 HOLDER PROVIDES NOTICE OF LOSS OF MEDICAID MEDICAL ASSISTANCE 15 WITHIN 90 DAYS AFTER THE DATE OF THE LOSS AND PAYS THE PREMIUM 16 ATTRIBUTABLE TO THE PERIOD EFFECTIVE AS OF THE DATE OF TERMINA-17 TION OF THE ASSISTANCE. ALL OF THE FOLLOWING APPLY TO THE REIN-**18 STITUTION OF A MEDICARE SUPPLEMENT CERTIFICATE UNDER THIS 19** SUBSECTION:

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

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

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

9 (2) INTEREST UNDER SUBSECTION (1) SHALL BE CALCULATED AT 10 6-MONTH INTERVALS FROM THE DATE THE FIRST PREMIUM PAYMENT WAS 11 RECEIVED AT A RATE OF INTEREST EQUAL TO 1% PLUS THE AVERAGE 12 INTEREST RATE PAID AT AUCTIONS OF 5-YEAR UNITED STATES TREASURY 13 NOTES DURING THE 6 MONTHS IMMEDIATELY PRECEDING JULY 1 AND 14 JANUARY 1, AS CERTIFIED BY THE STATE TREASURER, AND COMPOUNDED 15 ANNUALLY.

16 SEC. 473. A HEALTH CARE CORPORATION CERTIFICATE SHALL NOT 17 BE TITLED, ADVERTISED, SOLICITED, OR ISSUED FOR DELIVERY IN THIS 18 STATE AS A MEDICARE SUPPLEMENT CERTIFICATE UNLESS THE DEFINITIONS 19 AND TERMS CONTAINED IN THE CERTIFICATE ARE SUCH THAT COVERED BEN-20 EFITS UNDER THE CERTIFICATE ARE NOT MORE RESTRICTIVE THAN COVERED 21 BENEFITS UNDER MEDICARE AND THOSE REQUIRED TO BE PROVIDED UNDER 22 STATE LAW. A MEDICARE SUPPLEMENT CERTIFICATE SHALL CONTAIN A 23 DEFINITION OF MEDICARE AS THAT TERM IS DEFINED IN SECTION 451 OR 24 SUBSTANTIALLY SIMILAR TO THAT DEFINITION.

25 SEC. 475. A MEDICARE SUPPLEMENT CERTIFICATE SHALL NOT USE 26 WAIVERS TO EXCLUDE, LIMIT, OR REDUCE COVERAGE OR BENEFITS FOR

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1 SPECIFICALLY NAMED OR DESCRIBED PREEXISTING DISEASES OR PHYSICAL 2 CONDITIONS.

3 SEC. 477. (1) A MEDICARE SUPPLEMENT CERTIFICATE SHALL NOT 4 BE DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE IF THE CERTIFI-5 CATE PROVIDES BENEFITS THAT DUPLICATE BENEFITS PROVIDED BY 6 MEDICARE.

7 (2) APPLICATION FORMS OR A SUPPLEMENTARY APPLICATION OR 8 OTHER FORM TO BE SIGNED BY THE APPLICANT AND AGENT FOR MEDICARE 9 SUPPLEMENT CERTIFICATES SHALL INCLUDE THE FOLLOWING STATEMENTS 10 AND QUESTIONS DESIGNED TO INFORM AND ELICIT INFORMATION AS TO 11 WHETHER, AS OF THE DATE OF THE APPLICATION, THE APPLICANT HAS 12 ANOTHER MEDICARE SUPPLEMENT OR OTHER HEALTH INSURANCE POLICY, 13 CONTRACT, OR CERTIFICATE IN FORCE OR WHETHER A MEDICARE SUPPLE-14 MENT CERTIFICATE IS INTENDED TO REPLACE ANY DISABILITY OR OTHER 15 HEALTH CERTIFICATE PRESENTLY IN FORCE:

16

[STATEMENTS]

17 (1) YOU DO NOT NEED MORE THAN 1 MEDICARE SUPPLEMENT 18 CERTIFICATE.

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

21 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

1 REINSTITUTED IF REQUESTED WITHIN 90 DAYS OF LOSING MEDICAID 2 ELIGIBILITY.

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

6

[QUESTIONS]

7 THESE QUESTIONS SHOULD BE ANSWERED TO THE BEST OF YOUR8 KNOWLEDGE.

9 (1) DO YOU HAVE ANOTHER MEDICARE SUPPLEMENT INSURANCE 10 POLICY, CONTRACT, OR CERTIFICATE IN FORCE (INCLUDING AN INSURANCE 11 POLICY OR HEALTH MAINTENANCE ORGANIZATION CONTRACT)? IF SO, WITH 12 WHICH COMPANY?

13 (2) DO YOU HAVE ANY OTHER HEALTH INSURANCE POLICIES, CERTIF14 ICATES, OR CONTRACTS THAT PROVIDE BENEFITS THAT THIS MEDICARE
15 SUPPLEMENT CERTIFICATE WOULD DUPLICATE? IF SO, WITH WHICH
16 COMPANY? WHAT KIND OF POLICY, CONTRACT, OR CERTIFICATE?

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

20 (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.

1 (4) FOR A DIRECT RESPONSE HEALTH CARE CORPORATION, A COPY OF 2 THE APPLICATION OR SUPPLEMENT FORM, SIGNED BY THE APPLICANT, AND 3 ACKNOWLEDGED BY THE HEALTH CARE CORPORATION, SHALL BE RETURNED TO 4 THE APPLICANT BY THE HEALTH CARE CORPORATION UPON DELIVERY OF THE 5 CERTIFICATE.

6 (5) UPON DETERMINING THAT A SALE WILL INVOLVE REPLACEMENT OF 7 MEDICARE SUPPLEMENT COVERAGE, A HEALTH CARE CORPORATION, OTHER 8 THAN A DIRECT RESPONSE HEALTH CARE CORPORATION OR ITS AGENT, 9 SHALL FURNISH THE APPLICANT PRIOR TO ISSUANCE OR DELIVERY OF THE 10 MEDICARE SUPPLEMENT CERTIFICATE THE FOLLOWING NOTICE REGARDING 11 REPLACEMENT OF MEDICARE SUPPLEMENT COVERAGE. ONE COPY OF THE 12 NOTICE SIGNED BY THE APPLICANT AND THE AGENT, EXCEPT WHERE COVER-13 AGE IS SOLD WITHOUT AN AGENT, SHALL BE PROVIDED TO THE APPLICANT 14 AND AN ADDITIONAL SIGNED COPY SHALL BE RETAINED BY THE HEALTH . 15 CARE CORPORATION. A DIRECT RESPONSE HEALTH CARE CORPORATION 16 SHALL DELIVER TO THE APPLICANT AT THE TIME OF ISSUANCE OF THE 17 CERTIFICATE THE FOLLOWING NOTICE REGARDING REPLACEMENT OF MEDI-18 CARE SUPPLEMENT COVERAGE. THE NOTICE REGARDING REPLACEMENT OF 19 MEDICARE SUPPLEMENT COVERAGE SHALL BE PROVIDED IN SUBSTANTIALLY 20 THE FOLLOWING FORM AND IN NOT LESS THAN 10-POINT TYPE:

21

22

OF MEDICARE SUPPLEMENT COVERAGE

23 (HEALTH CARE CORPORATION'S NAME AND ADDRESS)
24 SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.
25 ACCORDING TO (YOUR APPLICATION) (INFORMATION YOU HAVE
26 FURNISHED), YOU INTEND TO DROP OR OTHERWISE TERMINATE EXISTING
27 MEDICARE SUPPLEMENT COVERAGE AND REPLACE IT WITH A CERTIFICATE TO

"NOTICE TO APPLICANT REGARDING REPLACEMENT

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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.

4 YOU SHOULD REVIEW THIS NEW COVERAGE CAREFULLY COMPARING IT 5 WITH ALL DISABILITY AND OTHER HEALTH COVERAGE YOU NOW HAVE AND 6 TERMINATE YOUR PRESENT COVERAGE ONLY IF, AFTER DUE CONSIDERATION, 7 YOU FIND THAT PURCHASE OF THIS MEDICARE SUPPLEMENT COVERAGE IS A 8 WISE DECISION.

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

11 (USE ADDITIONAL SHEETS AS NECESSARY.)

12 I HAVE REVIEWED YOUR CURRENT MEDICAL OR HEALTH COVERAGE. 13 THE REPLACEMENT OF COVERAGE INVOLVED IN THIS TRANSACTION DOES NOT 14 DUPLICATE COVERAGE, TO THE BEST OF MY KNOWLEDGE. THE REPLACEMENT 15 CERTIFICATE IS BEING PURCHASED FOR THE FOLLOWING REASONS (CHECK 16 1):

17 ADDITIONAL BENEFITS

18 NO CHANGE IN BENEFITS, BUT LOWER PREMIUMS

19 FEWER BENEFITS AND LOWER PREMIUMS

20 OTHER. (PLEASE SPECIFY)

21 1. HEALTH CONDITIONS THAT YOU MAY PRESENTLY HAVE

22 (PRE-EXISTING CONDITIONS) MAY NOT BE IMMEDIATELY OR FULLY COVERED
23 UNDER THE NEW CERTIFICATE. THIS COULD RESULT IN DENIAL OR DELAY
24 OF A CLAIM FOR BENEFITS UNDER THE NEW CERTIFICATE, WHEREAS A SIM25 ILAR CLAIM MIGHT HAVE BEEN PAYABLE UNDER YOUR PRESENT POLICY,
26 CONTRACT, OR CERTIFICATE. (THIS PARAGRAPH MAY BE DELETED BY A

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1 HEALTH CARE CORPORATION IF THE REPLACEMENT DOES NOT INVOLVE 2 APPLICATION OF A NEW PRE-EXISTING CONDITION LIMITATION.)

2. YOUR HEALTH CARE CORPORATION WILL WAIVE ANY TIME PERIODS
4 APPLICABLE TO PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINA5 TION PERIODS, OR PROBATIONARY PERIODS IN THE NEW CERTIFICATE FOR
6 SIMILAR BENEFITS TO THE EXTENT SUCH TIME WAS SPENT OR DEPLETED
7 UNDER THE ORIGINAL COVERAGE. (THIS PARAGRAPH MAY BE DELETED BY A
8 HEALTH CARE CORPORATION IF THE REPLACEMENT DOES NOT INVOLVE
9 APPLICATION OF A NEW PREEXISTING CONDITION LIMITATION.)

10 3. IF, AFTER THINKING ABOUT IT CAREFULLY, YOU STILL WISH TO 11 DROP YOUR PRESENT COVERAGE AND REPLACE IT WITH NEW COVERAGE, BE 12 CERTAIN TO TRUTHFULLY AND COMPLETELY ANSWER ALL QUESTIONS ON THE 13 APPLICATION CONCERNING YOUR MEDICAL AND HEALTH HISTORY. FAILURE 14 TO INCLUDE ALL MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY 15 PROVIDE A BASIS FOR THE HEALTH CARE CORPORATION TO DENY ANY 16 FUTURE CLAIMS AND TO REFUND YOUR PREMIUM AS THOUGH YOUR CERTIFI-17 CATE HAD NEVER BEEN IN FORCE. AFTER THE APPLICATION HAS BEEN 18 COMPLETED, AND BEFORE YOU SIGN IT, REVIEW IT CAREFULLY TO BE CER-19 TAIN THAT ALL INFORMATION HAS BEEN PROPERLY RECORDED. (IF THE 20 CERTIFICATE IS GUARANTEED ISSUE, THIS PARAGRAPH NEED NOT 21 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.

25

26 SIGNAT 27 (* SIG

SIGNATURE OF AGENT, BROKER, OR OTHER REPRESENTATIVE (* SIGNATURE NOT REQUIRED FOR DIRECT RESPONSE

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1	SALES.)
2 3	TYPED NAME AND ADDRESS OF AGENT OR BROKER
4	TITLD WARD AND ADDREDD OF AGENT ON DROKER
5	(DATE)
б	THE ABOVE "NOTICE TO APPLICANT" WAS DELIVERED TO ME ON:
7	
8	(DATE)
9 10	(APPLICANT'S SIGNATURE)
11 12	(APPLICANT'S PRINTED NAME)
13 14	(APPLICANT'S ADDRESS)
15 16	(POLICY, CERTIFICATE, OR CONTRACT NUMBER BEING REPLACED)"
17	SEC. 479. A HEALTH CARE CORPORATION SHALL NOT DENY OR CON-
18	DITION THE ISSUANCE OR EFFECTIVENESS OF A MEDICARE SUPPLEMENT
19	CERTIFICATE AVAILABLE FOR SALE IN THIS STATE, OR DISCRIMINATE IN
20	THE PRICING OF SUCH A CERTIFICATE, BECAUSE OF THE HEALTH STATUS,
21	CLAIMS EXPERIENCE, RECEIPT OF HEALTH CARE, OR MEDICAL CONDITION
22	OF AN APPLICANT IF AN APPLICATION FOR THE CERTIFICATE IS SUBMIT-
23	TED DURING THE 6-MONTH PERIOD BEGINNING WITH THE FIRST MONTH IN
24	WHICH AN INDIVIDUAL WHO IS 65 YEARS OF AGE OR OLDER FIRST
25	ENROLLED FOR BENEFITS UNDER MEDICARE PART B. EACH MEDICARE SUP-
26	PLEMENT CERTIFICATE CURRENTLY AVAILABLE FROM A HEALTH CARE CORPO-
27	RATION SHALL BE MADE AVAILABLE TO ALL APPLICANTS WHO QUALIFY
28	UNDER THIS SECTION WITHOUT REGARD TO AGE.
29	SEC. 481. (1) EACH HEALTH CARE CORPORATION OFFERING
30	NONGROUP OR GROUP CERTIFICATES IN THIS STATE SHALL PROVIDE

1 WITHOUT RESTRICTION, TO ANY PERSON WHO REQUESTS COVERAGE FROM A 2 HEALTH CARE CORPORATION AND HAS BEEN COVERED BY AN INSURER, 3 HEALTH MAINTENANCE ORGANIZATION, OR HEALTH CARE CORPORATION IF 4 THE PERSON WOULD NO LONGER BE COVERED BECAUSE HE OR SHE HAS 5 BECOME ELIGIBLE FOR MEDICARE OR IF THE PERSON LOSES COVERAGE 6 UNDER A GROUP CERTIFICATE AFTER BECOMING ELIGIBLE FOR MEDICARE, A 7 RIGHT OF CONTINUATION OR CONVERSION TO THEIR CHOICE OF THE BASIC 8 CORE BENEFITS AS DESCRIBED IN SECTION 455 OR A TYPE C MEDICARE 9 SUPPLEMENTAL PACKAGE AS DESCRIBED IN SECTION 461(5)(C) THAT IS 10 GUARANTEED RENEWABLE OR NONCANCELLABLE. A PERSON WHO IS HOSPI-11 TALIZED OR HAS BEEN INFORMED BY A PHYSICIAN THAT HE OR SHE WILL 12 REOUIRE HOSPITALIZATION WITHIN 30 DAYS AFTER THE TIME OF APPLICA-13 TION SHALL NOT BE ENTITLED TO COVERAGE UNDER THIS SUBSECTION 14 UNTIL THE DAY FOLLOWING THE DATE OF DISCHARGE. HOWEVER, IF THE 15 HOSPITALIZED PERSON WAS COVERED BY THE HEALTH CARE CORPORATION 16 IMMEDIATELY PRIOR TO BECOMING ELIGIBLE FOR MEDICARE OR IMMEDI-17 ATELY PRIOR TO LOSING COVERAGE UNDER A GROUP CERTIFICATE AFTER 18 BECOMING ELIGIBLE FOR MEDICARE, THE PERSON SHALL BE ELIGIBLE FOR 19 IMMEDIATE COVERAGE FROM THE PREVIOUS INSURER, HEALTH MAINTENANCE 20 ORGANIZATION, OR HEALTH CARE CORPORATION UNDER THIS SUBSECTION. 21 A PERSON SHALL NOT BE ENTITLED TO A MEDICARE SUPPLEMENTAL CERTIF-22 ICATE UNDER THIS SUBSECTION UNLESS THE PERSON PRESENTS SATISFAC-23 TORY PROOF TO THE HEALTH CARE CORPORATION THAT HE OR SHE WAS COV-24 ERED BY AN INSURER, HEALTH MAINTENANCE ORGANIZATION, OR HEALTH 25 CARE CORPORATION. A PERSON WHO WISHES COVERAGE UNDER THIS SUB-26 SECTION MUST EITHER REQUEST COVERAGE WITHIN 90 DAYS BEFORE OR 90 27 DAYS AFTER THE MONTH HE OR SHE BECOMES ELIGIBLE FOR MEDICARE OR

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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 ELI 8 GIBLE FOR MEDICARE.

(2) EXCEPT AS PROVIDED IN SECTION 483, A PERSON NOT COVERED 9 10 UNDER A NONGROUP OR GROUP CERTIFICATE AS SPECIFIED IN 11 SUBSECTION (1), AFTER APPLYING FOR COVERAGE UNDER A MEDICARE SUP-12 PLEMENTAL CERTIFICATE REQUIRED TO BE OFFERED UNDER 13 SUBSECTION (1), IS ENTITLED TO COVERAGE UNDER A MEDICARE SUPPLE-14 MENTAL CERTIFICATE THAT MAY INCLUDE A PROVISION FOR EXCLUSION 15 FROM PREEXISTING CONDITIONS FOR 6 MONTHS AFTER THE INCEPTION OF 16 COVERAGE, CONSISTENT WITH THE PROVISIONS OF SECTION 469(2)(A). (3) EACH HEALTH CARE CORPORATION OFFERING NONGROUP CERTIFI-17 18 CATES IN THIS STATE SHALL GIVE TO EACH PERSON WHO IS COVERED WITH 19 THE HEALTH CARE CORPORATION AT THE TIME HE OR SHE BECOMES ELIGI-20 BLE FOR MEDICARE, AND TO EACH APPLICANT OF THE HEALTH CARE CORPO-21 RATION WHO IS ELIGIBLE FOR MEDICARE, WRITTEN NOTICE OF THE AVAIL-22 ABILITY OF COVERAGE UNDER THIS SECTION. EACH GROUP CERTIFICATE

23 HOLDER IN THIS STATE SHALL GIVE TO EACH MEMBER WHO IS COVERED AT 24 THE TIME HE OR SHE BECOMES ELIGIBLE FOR MEDICARE, WRITTEN NOTICE 25 OF THE AVAILABILITY OF COVERAGE UNDER THIS SECTION.

26 SEC. 483. IF A MEDICARE SUPPLEMENT CERTIFICATE REPLACES 27 ANOTHER MEDICARE SUPPLEMENT POLICY, CONTRACT, OR CERTIFICATE, THE

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

6 SEC. 485. (1) EACH HEALTH CARE CORPORATION MARKETING MEDI7 CARE SUPPLEMENT COVERAGE IN THIS STATE DIRECTLY OR THROUGH ITS
8 AGENTS SHALL DO ALL OF THE FOLLOWING:

9 (A) ESTABLISH MARKETING PROCEDURES TO ENSURE THAT ANY COM-10 PARISON OF POLICIES BY ITS AGENTS WILL BE FAIR AND ACCURATE.

(B) ESTABLISH MARKETING PROCEDURES TO ENSURE EXCESSIVE COV12 ERAGE IS NOT SOLD OR ISSUED.

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

17 (D) ESTABLISH AUDITABLE PROCEDURES FOR VERIFYING COMPLIANCE18 WITH THIS SUBSECTION.

19 (2) IN RECOMMENDING THE PURCHASE OR REPLACEMENT OF ANY MEDI20 CARE SUPPLEMENT COVERAGE, AN AGENT SHALL MAKE REASONABLE EFFORTS
21 TO DETERMINE THE APPROPRIATENESS OF A RECOMMENDED PURCHASE OR
22 REPLACEMENT.

(3) ANY SALE OF MEDICARE SUPPLEMENT COVERAGE THAT WILL PRO24 VIDE AN INDIVIDUAL WITH MORE THAN 1 MEDICARE SUPPLEMENT POLICY,
25 CONTRACT, OR CERTIFICATE IS PROHIBITED.

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

1 FIRST PAGE OF THE CERTIFICATE THE FOLLOWING: "NOTICE TO BUYER: 2 THIS CERTIFICATE MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES."

3 SEC. 487. (1) ON OR BEFORE MARCH 1 OF EACH YEAR, EVERY 4 HEALTH CARE CORPORATION PROVIDING MEDICARE SUPPLEMENT COVERAGE IN 5 THIS STATE SHALL REPORT TO THE COMMISSIONER THE FOLLOWING INFOR-6 MATION FOR EVERY INDIVIDUAL RESIDENT OF THIS STATE FOR WHICH THE 7 HEALTH CARE CORPORATION HAS IN FORCE MORE THAN 1 MEDICARE SUPPLE-8 MENT CERTIFICATE:

9 (A) CERTIFICATE NUMBER.

10 (B) DATE OF ISSUANCE.

11 (2) THE ITEMS IN SUBSECTION (1) SHALL BE GROUPED BY INDIVID-12 UAL CERTIFICATE HOLDER.

SEC. 491. (1) EACH MEDICARE SUPPLEMENT CERTIFICATE SHALL 13 14 INCLUDE A RENEWAL OR CONTINUATION PROVISION. THE PROVISION SHALL 15 BE APPROPRIATELY CAPTIONED, SHALL APPEAR ON THE FIRST PAGE OF THE 16 CERTIFICATE, AND SHALL CLEARLY STATE THE TERM OF COVERAGE FOR 17 WHICH THE CERTIFICATE IS ISSUED AND FOR WHICH IT MAY BE RENEWED. 18 THE PROVISION SHALL INCLUDE ANY RESERVATION BY THE HEALTH CARE 19 CORPORATION OF THE RIGHT TO CHANGE PREMIUMS AND ANY AUTOMATIC 20 RENEWAL PREMIUM INCREASES BASED ON THE CERTIFICATE HOLDER'S AGE. (2) IF A MEDICARE SUPPLEMENT CERTIFICATE IS TERMINATED BY 21 22 THE GROUP CERTIFICATE HOLDER AND IS NOT REPLACED AS PROVIDED 23 UNDER SUBSECTION (4), THE HEALTH CARE CORPORATION SHALL OFFER 24 CERTIFICATE HOLDERS A NONGROUP MEDICARE SUPPLEMENT CERTIFICATE 25 THAT AT THE OPTION OF THE CERTIFICATE HOLDER PROVIDES FOR CONTIN-26 UATION OF THE BENEFITS CONTAINED IN THE GROUP CERTIFICATE OR

1 PROVIDES FOR SUCH BENEFITS AS OTHERWISE MEET THE REQUIREMENTS OF 2 SECTION 469.

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

(4) IF A GROUP MEDICARE SUPPLEMENT POLICY, CONTRACT, OR CER11 TIFICATE IS REPLACED BY ANOTHER GROUP MEDICARE SUPPLEMENT POLICY,
12 CONTRACT, OR CERTIFICATE PURCHASED BY THE SAME CERTIFICATE
13 HOLDER, THE SUCCEEDING ISSUER SHALL OFFER COVERAGE TO ALL PERSONS
14 COVERED UNDER THE OLD GROUP POLICY, CONTRACT, OR CERTIFICATE ON
15 ITS DATE OF TERMINATION. COVERAGE UNDER THE NEW CERTIFICATE
16 SHALL NOT RESULT IN ANY EXCLUSION FOR PREEXISTING CONDITIONS THAT
17 WOULD HAVE BEEN COVERED UNDER THE GROUP POLICY, CONTRACT, OR CER18 TIFICATE BEING REPLACED.

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

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

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

14 (3) IF A MEDICARE SUPPLEMENT CERTIFICATE CONTAINS ANY LIMI15 TATIONS WITH RESPECT TO PREEXISTING CONDITIONS, THE LIMITATIONS
16 SHALL APPEAR AS A SEPARATE PARAGRAPH OF THE CERTIFICATE AND SHALL
17 BE LABELED AS "PREEXISTING CONDITION LIMITATIONS".

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

(5) A MEDICARE SUPPLEMENT CERTIFICATE SHALL HAVE A NOTICE
22 PROMINENTLY PRINTED ON THE FIRST PAGE OR ATTACHED THERETO STATING
23 THAT A MEMBER SHALL HAVE THE RIGHT TO RETURN THE POLICY OR CER24 TIFICATE WITHIN 30 DAYS OF ITS DELIVERY AND TO HAVE THE PREMIUM
25 REFUNDED IF, AFTER EXAMINATION OF THE CERTIFICATE, THE MEMBER IS
26 NOT SATISFIED FOR ANY REASON.

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(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, ENDORSE MENTS, 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

(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
18 THE ANNUAL EFFECTIVE DATE OF ANY MEDICARE BENEFIT CHANGES, EVERY
19 HEALTH CARE CORPORATION DELIVERING OR ISSUING FOR DELIVERY IN
20 THIS STATE MEDICARE SUPPLEMENT CERTIFICATES SHALL NOTIFY EACH
21 COVERED CERTIFICATE HOLDER OF MODIFICATIONS MADE TO ITS MEDICARE
22 SUPPLEMENT CERTIFICATES IN A FORMAT ACCEPTABLE TO THE
23 COMMISSIONER. THE NOTICE SHALL BE IN OUTLINE FORM, CONTAIN CLEAR
24 AND SIMPLE LANGUAGE, SHALL NOT CONTAIN OR BE ACCOMPANIED BY ANY
25 SOLICITATION, AND SHALL INCLUDE BOTH OF THE FOLLOWING:

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1 (A) A DESCRIPTION OF REVISIONS TO THE MEDICARE PROGRAM AND 2 OF EACH MODIFICATION MADE TO THE COVERAGE PROVIDED UNDER THE 3 MEDICARE SUPPLEMENT CERTIFICATE.

4, (B) WHETHER A PREMIUM ADJUSTMENT IS DUE TO CHANGES IN 5 MEDICARE.

6 SEC. 495. (1) ANY CERTIFICATE ISSUED FOR DELIVERY IN THIS 7 STATE TO PERSONS ELIGIBLE FOR MEDICARE BY REASON OF AGE SHALL 8 NOTIFY SUBSCRIBERS UNDER THE CERTIFICATE BY REASON OF AGE SHALL 9 NOT A MEDICARE SUPPLEMENT CERTIFICATE. THE NOTICE SHALL EITHER 10 BE PRINTED OR ATTACHED TO THE FIRST PAGE OF THE COVERAGE OUTLINE 11 DELIVERED TO SUBSCRIBERS UNDER THE CERTIFICATE, OR IF A COVERAGE 12 OUTLINE IS NOT DELIVERED, TO THE FIRST PAGE OF THE CERTIFICATE 13 DELIVERED TO SUBSCRIBERS. THE NOTICE SHALL BE IN NOT LESS THAN 14 12-POINT TYPE, AND SHALL CONTAIN THE FOLLOWING LANGUAGE:

15 "THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE.
16 IT IS NOT DESIGNED TO FIT WITH MEDICARE. IT MAY NOT FIT ALL OF
17 THE GAPS IN MEDICARE AND IT MAY DUPLICATE SOME MEDICARE
18 BENEFITS. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE MEDICARE
19 SUPPLEMENT BUYER'S GUIDE AVAILABLE FROM THE COMPANY. IF YOU
20 DECIDE TO CONSIDER BUYING THIS CERTIFICATE, BE SURE YOU UNDER21 STAND WHAT IT COVERS, WHAT IT DOES NOT COVER, AND WHETHER IT
22 DUPLICATES COVERAGE YOU ALREADY HAVE."

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

25 SEC. 496. THE FOLLOWING ACTS AND PRACTICES ARE PROHIBITED 26 IN THE MARKETING OR SALE OF MEDICARE SUPPLEMENT COVERAGE:

1

(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 CERTIFI CATE 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 MARKET12 ING HAVING THE EFFECT OF OR TENDING TO INDUCE THE PURCHASE OF
13 HEALTH COVERAGE THROUGH FORCE, FRIGHT, THREAT WHETHER EXPLICIT OR
14 IMPLIED, OR UNDUE PRESSURE TO PURCHASE OR RECOMMEND THE PURCHASE
15 OF HEALTH COVERAGE.

16 (C) COLD LEAD ADVERTISING. MAKING USE DIRECTLY OR INDI17 RECTLY OF ANY METHOD OF MARKETING THAT FAILS TO DISCLOSE IN A
18 CONSPICUOUS MANNER THAT A PURPOSE OF THE METHOD OF MARKETING IS
19 SOLICITATION OF HEALTH COVERAGE AND THAT CONTACT WILL BE MADE BY
20 A HEALTH CARE CORPORATION AGENT OR COMPANY.

21 SEC. 497. EACH HEALTH CARE CORPORATION PROVIDING MEDICARE 22 SUPPLEMENT COVERAGE IN THIS STATE SHALL FILE WITH THE COMMIS-23 SIONER FOR REVIEW A COPY OF ANY WRITTEN, RADIO, OR TELEVISION 24 ADVERTISEMENT FOR MEDICARE SUPPLEMENT COVERAGE INTENDED FOR USE 25 IN THIS STATE AT LEAST 45 DAYS BEFORE THE DATE THE HEALTH CARE 26 CORPORATION DESIRES TO USE THE ADVERTISING. THE FILING SHALL 27 INCLUDE A SAMPLE OR PHOTOCOPY OF ALL APPLICABLE MEDICARE

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1 SUPPLEMENT CERTIFICATES AND RELATED FORMS AND THE APPROVAL STATUS 2 OF THE CERTIFICATES AND FORMS.

3 SEC. 498. (1) A HEALTH CARE CORPORATION SHALL NOT DELIVER 4 OR ISSUE FOR DELIVERY A MEDICARE SUPPLEMENT CERTIFICATE TO A RES-5 IDENT OF THIS STATE UNLESS THE CERTIFICATE FORM HAS BEEN FILED 6 WITH AND APPROVED BY THE COMMISSIONER IN ACCORDANCE WITH FILING 7 REQUIREMENTS AND PROCEDURES PRESCRIBED BY THE COMMISSIONER.

8 (2) A HEALTH CARE CORPORATION SHALL NOT USE OR CHANGE PRE-9 MIUM RATES FOR A MEDICARE SUPPLEMENT CERTIFICATE UNLESS THE 10 RATES, RATING SCHEDULE, AND SUPPORTING DOCUMENTATION HAVE BEEN 11 FILED WITH AND APPROVED BY THE COMMISSIONER IN ACCORDANCE WITH 12 THE FILING REQUIREMENTS AND PROCEDURES PRESCRIBED BY THE 13 COMMISSIONER.

14 (3) EXCEPT AS PROVIDED IN SUBSECTION (4), A HEALTH CARE COR15 PORATION SHALL NOT FILE FOR APPROVAL MORE THAN 1 FORM OF A CER16 TIFICATE FOR EACH GROUP AND NONGROUP STANDARD MEDICARE SUPPLEMENT
17 BENEFIT PLAN.

18 (4) WITH THE APPROVAL OF THE COMMISSIONER, A HEALTH CARE
19 CORPORATION MAY OFFER UP TO 4 ADDITIONAL CERTIFICATE FORMS OF THE
20 SAME TYPE FOR THE SAME STANDARD MEDICARE SUPPLEMENT BENEFIT PLAN,
21 1 FOR EACH OF THE FOLLOWING CASES:

22 (A) THE INCLUSION OF NEW OR INNOVATIVE BENEFITS.

(B) THE ADDITION OF EITHER DIRECT RESPONSE OR AGENT MARKET24 ING METHODS.

25 (C) THE ADDITION OF EITHER GUARANTEED ISSUE OR UNDERWRITTEN26 COVERAGE.

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

3 (5) EXCEPT AS PROVIDED IN SUBSECTION (6), A HEALTH CARE COR-4 PORATION SHALL CONTINUE TO MAKE AVAILABLE FOR PURCHASE ANY MEDI-5 CARE SUPPLEMENT CERTIFICATE FORM ISSUED AFTER THE EFFECTIVE DATE 6 OF THIS PART THAT HAS BEEN APPROVED BY THE COMMISSIONER. A MEDI-7 CARE SUPPLEMENT CERTIFICATE FORM SHALL NOT BE CONSIDERED TO BE 8 AVAILABLE FOR PURCHASE UNLESS THE HEALTH CARE CORPORATION HAS 9 ACTIVELY OFFERED IT FOR SALE IN THE PREVIOUS 12 MONTHS.

(6) A HEALTH CARE CORPORATION MAY DISCONTINUE THE AVAILABIL11 ITY OF A MEDICARE SUPPLEMENT CERTIFICATE FORM IF THE HEALTH CARE
12 CORPORATION PROVIDES TO THE COMMISSIONER IN WRITING ITS DECISION
13 TO DISCONTINUE AT LEAST 30 DAYS PRIOR TO DISCONTINUING THE AVAIL14 ABILITY OF THE FORM OF THE MEDICARE SUPPLEMENT CERTIFICATE.
15 AFTER RECEIPT OF THE NOTICE BY THE COMMISSIONER, THE HEALTH CARE
16 CORPORATION SHALL NO LONGER OFFER FOR SALE THE MEDICARE SUPPLE17 MENT CERTIFICATE FORM IN THIS STATE.

(7) A HEALTH CARE CORPORATION THAT DISCONTINUES THE AVAIL19 ABILITY OF A MEDICARE SUPPLEMENT CERTIFICATE FORM PURSUANT TO
20 SUBSECTION (6) SHALL NOT FILE FOR APPROVAL A NEW MEDICARE SUPPLE21 MENT CERTIFICATE FORM OF THE SAME TYPE FOR THE SAME STANDARD
22 MEDICARE SUPPLEMENT BENEFIT PLAN AS THE DISCONTINUED FORM FOR A
23 PERIOD OF 5 YEARS AFTER THE HEALTH CARE CORPORATION PROVIDES
24 NOTICE TO THE COMMISSIONER OF THE DISCONTINUANCE. THE PERIOD OF
25 DISCONTINUANCE MAY BE REDUCED IF THE COMMISSIONER DETERMINES THAT
26 A SHORTER PERIOD IS APPROPRIATE.

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1 (8) THE SALE OR OTHER TRANSFER OF MEDICARE SUPPLEMENT 2 BUSINESS TO ANOTHER INSURER, HEALTH MAINTENANCE ORGANIZATION, OR 3 HEALTH CARE CORPORATION SHALL BE CONSIDERED A DISCONTINUANCE FOR 4 THE PURPOSES OF THIS SECTION.

5 (9) EACH HEALTH CARE CORPORATION THAT ISSUES MEDICARE SUP-6 PLEMENT CERTIFICATES FOR DELIVERY IN THIS STATE SHALL COMPLY WITH 7 SECTIONS 1842 AND 1882 OF TITLE XVIII OF THE SOCIAL SECURITY ACT, 8 CHAPTER 531, 49 STAT. 620, 42 U.S.C. 1395u AND 1395ss, AND SHALL 9 CERTIFY THAT COMPLIANCE ON THE MEDICARE SUPPLEMENT EXPERIENCE 10 REPORTING FORM.

11 (10) FOR THE PURPOSES OF THIS SECTION, "TYPE" MEANS A GROUP
12 CERTIFICATE, A NONGROUP CERTIFICATE, A GROUP MEDICARE SELECT CER13 TIFICATE, OR A NONGROUP MEDICARE SELECT CERTIFICATE.

14 SEC. 499. (1) A HEALTH CARE CORPORATION SHALL DO ALL OF THE15 FOLLOWING:

16 (A) ACCEPT A NOTICE FROM A MEDICARE CARRIER ON DUALLY 17 ASSIGNED CLAIMS SUBMITTED BY PARTICIPATING PHYSICIANS AND SUPPLI-18 ERS AS A CLAIM FOR BENEFITS IN PLACE OF ANY OTHER CLAIM FORM OTH-19 ERWISE REQUIRED AND MAKE A PAYMENT DETERMINATION ON THE BASIS OF 20 THE INFORMATION CONTAINED IN THAT NOTICE.

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

23 (C) PAY THE PARTICIPATING PHYSICIAN OR SUPPLIER DIRECTLY.

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

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1 (E) PAY USER FEES FOR CLAIM NOTICES THAT ARE TRANSMITTED 2 ELECTRONICALLY OR OTHERWISE.

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

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

9 SEC. 499A. (1) A PERSON SHALL NOT KNOWINGLY SELL A HEALTH 10 CARE CORPORATION CERTIFICATE TO AN INDIVIDUAL ENTITLED TO BENE-11 FITS UNDER PART A OR ENROLLED UNDER PART B OF MEDICARE WITH 12 KNOWLEDGE THAT THE CERTIFICATE SUBSTANTIALLY DUPLICATES HEALTH 13 BENEFITS TO WHICH THE INDIVIDUAL IS OTHERWISE ENTITLED, OTHER 14 THAN BENEFITS TO WHICH THE INDIVIDUAL IS ENTITLED UNDER A 15 REQUIREMENT OF STATE OR FEDERAL LAW OTHER THAN MEDICARE. A 16 PERSON WHO VIOLATES THIS SUBSECTION IS GUILTY OF A MISDEMEANOR 17 PUNISHABLE BY IMPRISONMENT FOR NOT MORE THAN 2 YEARS, OR A FINE 18 OF NOT MORE THAN \$10,000.00, OR BOTH. THE COURT MAY ORDER A 19 PERSON CONVICTED UNDER THIS SUBSECTION TO PAY RESTITUTION TO 20 INDIVIDUALS FOR EXPENSES INCURRED AS A RESULT OF VIOLATION OF , 21 THIS SUBSECTION. FOR PURPOSES OF THIS SUBSECTION, BENEFITS THAT 22 ARE PAYABLE TO OR ON BEHALF OF AN INDIVIDUAL WITHOUT REGARD TO 23 OTHER HEALTH BENEFIT COVERAGE OF THE INDIVIDUAL SHALL NOT BE CON-24 SIDERED AS DUPLICATIVE. THE SELLING OF A GROUP CERTIFICATE OF 25 THE TRUSTEES OF A FUND ESTABLISHED BY 1 OR MORE EMPLOYERS, LABOR 26 ORGANIZATIONS, OR BOTH, FOR EMPLOYEES, FORMER EMPLOYEES, OR BOTH, 27 OR FOR MEMBERS OR FORMER MEMBERS, OR BOTH, OF LABOR

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1 ORGANIZATIONS, SHALL NOT BE CONSIDERED TO BE A VIOLATION OF THIS 2 SUBSECTION.

3 (2) A PERSON SHALL NOT FALSELY ASSUME OR PRETEND TO BE 4 ACTING OR MISREPRESENT IN ANY WAY THAT HE OR SHE IS ACTING UNDER 5 THE AUTHORITY OF OR IN ASSOCIATION WITH MEDICARE OR ANY STATE OR 6 FEDERAL AGENCY, FOR THE PURPOSE OF SELLING OR ATTEMPTING TO SELL 7 HEALTH COVERAGE OR, IN SUCH A PRETENDED CHARACTER, DEMAND OR 8 OBTAIN MONEY, PAPER, DOCUMENTS, OR ANY THING OF VALUE. A PERSON 9 WHO VIOLATES THIS SUBSECTION IS GUILTY OF A MISDEMEANOR PUNISH-10 ABLE BY IMPRISONMENT FOR NOT MORE THAN 2 YEARS, OR A FINE OF NOT 11 MORE THAN \$10,000.00, OR BOTH.

12 (3) A PERSON SHALL NOT SOLICIT, OFFER FOR SALE, OR DELIVER A 13 MEDICARE SUPPLEMENT CERTIFICATE IN THIS STATE, UNLESS THE CERTIF-14 ICATE HAS BEEN APPROVED BY THE COMMISSIONER. A PERSON WHO VIO-15 LATES THIS SUBSECTION IS GUILTY OF A MISDEMEANOR PUNISHABLE BY 16 IMPRISONMENT FOR NOT MORE THAN 1 YEAR, OR A FINE OF NOT MORE THAN 17 \$5,000.00, OR BOTH.

18 Section 2. Sections 411 to 413a of Act No. 350 of the 19 Public Acts of 1980, being sections 550.1411 to 550.1413a of the 20 Michigan Compiled Laws, are repealed.

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Final page.

DKH