

**SUBSTITUTE FOR  
HOUSE BILL NO. 5235**

A bill to amend 1956 PA 218, entitled  
"The insurance code of 1956,"  
by amending sections 3801, 3803, 3807, 3808, 3809, 3811, 3815,  
3819, 3831, and 3839 (MCL 500.3801, 500.3803, 500.3807, 500.3808,  
500.3809, 500.3811, 500.3815, 500.3819, 500.3831, and 500.3839),  
sections 3801, 3807, 3809, 3811, 3815, 3819, 3831, and 3839 as  
amended by 2006 PA 462 and sections 3803 and 3808 as added by  
1992 PA 84, and by adding sections 3807a, 3809a, 3811a, and  
3819a.

**THE PEOPLE OF THE STATE OF MICHIGAN ENACT:**

- 1       Sec. 3801. As used in this chapter:  
2       (a) "Applicant" means:  
3       (i) For an individual medicare supplement policy, the person  
4 who seeks to contract for benefits.

1           (ii) For a group medicare supplement policy or certificate,  
2 the proposed certificate holder.

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

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

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

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

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

18           (i) A group health plan.

19           (ii) Health insurance coverage.

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

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

23           (v) Chapter 55 of title 10 of the United States Code, 10 USC  
24 1071 to 1110.

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

27           (vii) A state health benefits risk pool.

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

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

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

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

11 (h) "Employee welfare benefit plan" means a plan, fund, or  
12 program of employee benefits as defined in section 3 of subtitle  
13 A of title I of the employee retirement income security act of  
14 1974, 29 USC 1002.

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

20 (j) "Insurer" includes any entity, including a health care  
21 corporation operating pursuant to the nonprofit health care  
22 corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704,  
23 **AND A HEALTH MAINTENANCE ORGANIZATION OPERATING PURSUANT TO**  
24 **CHAPTER 35** delivering or issuing for delivery in this state  
25 medicare supplement policies.

26 (k) "Medicaid" means title XIX of the social security act,  
27 42 USC 1396 to 1396v.

1 (l) "Medicare" means title XVIII of the social security act,  
2 42 USC 1395 to ~~1395ggg~~ **1395HHH**.

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

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

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

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

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

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

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

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

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

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

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

26 (T) ~~(g)~~ "Policy form" means the form on which the policy or  
27 certificate is delivered or issued for delivery by the insurer.

1 (U) ~~(r)~~ "Secretary" means the secretary of the United States  
2 department of health and human services.

3 (V) ~~(s)~~ "Social security act" means the social security act,  
4 42 USC 301 to 1397jj.

5 Sec. 3803. (1) Except as provided in ~~subsection~~ **SUBSECTIONS**  
6 (2) **AND (3)**, this chapter applies to a medicare supplement policy  
7 delivered, issued for delivery, or renewed in this state. ~~on or~~  
8 ~~after the effective date of this chapter.~~

9 (2) Sections **3807**, 3809, 3811, and ~~3819(1) do not apply~~ **3819**  
10 **APPLY** to a medicare supplement policy **DELIVERED OR** issued ~~before~~  
11 ~~the effective date of this chapter~~ **FOR DELIVERY IN THIS STATE ON**  
12 **OR AFTER JUNE 2, 1992 WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR**  
13 **TO JUNE 1, 2010.**

14 (3) **SECTIONS 3807A, 3809A, 3811A, AND 3819A APPLY TO A**  
15 **MEDICARE SUPPLEMENT POLICY DELIVERED OR ISSUED FOR DELIVERY IN**  
16 **THIS STATE WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE**  
17 **1, 2010.**

18 Sec. 3807. (1) Every insurer issuing a medicare supplement  
19 insurance policy in this state shall make available a medicare  
20 supplement insurance policy that includes a basic core package of  
21 benefits to each prospective insured. An insurer issuing a  
22 medicare supplement insurance policy in this state may make  
23 available to prospective insureds benefits pursuant to section  
24 3809 that are in addition to, but not instead of, the basic core  
25 package. The basic core package of benefits shall include all of  
26 the following:

27 (a) Coverage of part A medicare eligible expenses for

1 hospitalization to the extent not covered by medicare from the  
2 ~~61st-SIXTY-FIRST~~ day through the ~~90th-NINETIETH~~ day in any  
3 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  
8 coverage including the lifetime reserve days, coverage of 100% of  
9 the medicare part A eligible expenses for hospitalization paid at  
10 the applicable prospective payment system rate or other  
11 appropriate medicare standard of payment, subject to a lifetime  
12 maximum benefit of an additional 365 days. **THE PROVIDER SHALL**  
13 **ACCEPT THE INSURER'S PAYMENT AS PAYMENT IN FULL AND MAY NOT BILL**  
14 **THE INSURED FOR ANY BALANCE.**

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

19 (e) Coverage for the coinsurance amount, or the copayment  
20 amount paid for hospital outpatient department services under a  
21 prospective payment system, of medicare eligible expenses under  
22 part B regardless of hospital confinement, subject to the  
23 medicare part B deductible.

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

25 (a) Standardized medicare supplement benefit plan K shall  
26 consist of the following:

27 (i) Coverage of 100% of the part A hospital coinsurance

1 amount for each day used from the sixty-first day through the  
2 ninetieth day in any medicare benefit period.

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

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

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

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

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



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

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

12           (ix) Coverage of 100% of the cost sharing for medicare part B  
13 preventive services after the policyholder pays the part B  
14 deductible.

15           (x) Coverage of 100% of all cost sharing under medicare  
16 parts A and B for the balance of the calendar year after the  
17 individual has reached the out-of-pocket limitation on annual  
18 expenditures under medicare parts A and B of \$4,000.00 in 2006,  
19 indexed each year by the appropriate inflation adjustment  
20 specified by the secretary of the United States department of  
21 health and human services.

22           (b) Standardized medicare supplement benefit plan L shall  
23 consist of the following:

24           (i) The benefits described in subdivision (a) (i), (ii), (iii),  
25 and (ix).

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

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

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

6 SEC. 3807A. (1) THIS SECTION APPLIES TO ALL MEDICARE  
7 SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR ISSUED FOR  
8 DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1,  
9 2010. A POLICY OR CERTIFICATE SHALL NOT BE ADVERTISED, SOLICITED,  
10 DELIVERED, OR ISSUED FOR DELIVERY IN THIS STATE AS A MEDICARE  
11 SUPPLEMENT POLICY OR CERTIFICATE UNLESS IT COMPLIES WITH THESE  
12 BENEFIT STANDARDS. AN ISSUER SHALL NOT OFFER ANY 1990 PLAN FOR  
13 SALE ON OR AFTER JUNE 1, 2010. BENEFIT STANDARDS APPLICABLE TO  
14 MEDICARE SUPPLEMENT POLICIES AND CERTIFICATES ISSUED BEFORE JUNE  
15 1, 2010 REMAIN SUBJECT TO THE REQUIREMENTS OF SECTION 3807.

16 (2) EVERY INSURER ISSUING A MEDICARE SUPPLEMENT INSURANCE  
17 POLICY IN THIS STATE SHALL MAKE AVAILABLE A MEDICARE SUPPLEMENT  
18 INSURANCE POLICY THAT INCLUDES A BASIC CORE PACKAGE OF BENEFITS  
19 TO EACH PROSPECTIVE INSURED. AN INSURER ISSUING A MEDICARE  
20 SUPPLEMENT INSURANCE POLICY IN THIS STATE MAY MAKE AVAILABLE TO  
21 PROSPECTIVE INSURED'S BENEFITS PURSUANT TO SECTION 3809A THAT ARE  
22 IN ADDITION TO, BUT NOT INSTEAD OF, THE BASIC CORE PACKAGE. THE  
23 BASIC CORE PACKAGE OF BENEFITS SHALL INCLUDE ALL OF THE  
24 FOLLOWING:

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

1 PERIOD.

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

5 (C) UPON EXHAUSTION OF THE MEDICARE HOSPITAL INPATIENT  
6 COVERAGE INCLUDING THE LIFETIME RESERVE DAYS, COVERAGE OF 100% OF  
7 THE MEDICARE PART A ELIGIBLE EXPENSES FOR HOSPITALIZATION PAID AT  
8 THE APPLICABLE PROSPECTIVE PAYMENT SYSTEM RATE OR OTHER  
9 APPROPRIATE MEDICARE STANDARD OF PAYMENT, SUBJECT TO A LIFETIME  
10 MAXIMUM BENEFIT OF AN ADDITIONAL 365 DAYS. THE PROVIDER SHALL  
11 ACCEPT THE INSURER'S PAYMENT AS PAYMENT IN FULL AND MAY NOT BILL  
12 THE INSURED FOR ANY BALANCE.

13 (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, OR THE COPAYMENT  
18 AMOUNT PAID FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES UNDER A  
19 PROSPECTIVE PAYMENT SYSTEM, OF MEDICARE ELIGIBLE EXPENSES UNDER  
20 PART B REGARDLESS OF HOSPITAL CONFINEMENT, SUBJECT TO THE  
21 MEDICARE PART B DEDUCTIBLE.

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

24 Sec. 3808. Every insurer issuing a medicare supplement  
25 insurance policy in this state shall make available a medicare  
26 supplement insurance policy that includes the benefits provided  
27 in section 3811(5)(c) OR 3811A(6)(C), WHICHEVER IS APPLICABLE.

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

5           (a) Medicare part A deductible: coverage for all of the  
6 medicare part A inpatient hospital deductible amount per benefit  
7 period.

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

13           (c) Medicare part B deductible: coverage for all of the  
14 medicare part B deductible amount per calendar year regardless of  
15 hospital confinement.

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

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

26           (f) Basic outpatient prescription drug benefit: coverage for  
27 50% of outpatient prescription drug charges, after a \$250.00

1 calendar year deductible, to a maximum of \$1,250.00 in benefits  
2 received by the insured per calendar year, to the extent not  
3 covered by medicare. The outpatient prescription drug benefit may  
4 be included for sale or issuance in a medicare supplement policy  
5 until January 1, 2006.

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

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

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

27 (i) An annual clinical preventive medical history and

1 physical examination that may include tests and services from  
2 subparagraph (ii) and patient education to address preventive  
3 health care measures.

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

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

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

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

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

27 (iv) Seven visits in any 1 week.

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

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

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

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

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

22 (2) Reimbursement for the preventive screening tests and  
23 services under subsection (1) (i) (ii) shall be for the actual  
24 charges up to 100% of the medicare-approved amount for each test  
25 or service, as if medicare were to cover the test or service as  
26 identified in the American medical association current procedural  
27 terminology codes, to a maximum of \$120.00 annually under this

1 benefit. This benefit shall not include payment for any procedure  
2 covered by medicare.

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

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

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

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

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

20 **(4) THIS SECTION APPLIES TO MEDICARE SUPPLEMENT POLICIES OR**  
21 **CERTIFICATES DELIVERED OR ISSUED FOR DELIVERY ON OR AFTER JUNE 2,**  
22 **1992 WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010.**

23 **SEC. 3809A. (1) THIS SECTION APPLIES TO ALL MEDICARE**  
24 **SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR ISSUED FOR**  
25 **DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1,**  
26 **2010.**

27 **(2) IN ADDITION TO THE BASIC CORE PACKAGE OF BENEFITS**



1 REQUIRED UNDER SECTION 3807A, THE FOLLOWING BENEFITS MAY BE  
2 INCLUDED IN A MEDICARE SUPPLEMENT INSURANCE POLICY AND IF  
3 INCLUDED SHALL CONFORM TO SECTION 3811A(6) (B) TO (J):

4 (A) MEDICARE PART A DEDUCTIBLE: COVERAGE FOR 100% OF THE  
5 MEDICARE PART A INPATIENT HOSPITAL DEDUCTIBLE AMOUNT PER BENEFIT  
6 PERIOD.

7 (B) MEDICARE PART A DEDUCTIBLE: COVERAGE FOR 50% OF THE  
8 MEDICARE PART A INPATIENT HOSPITAL DEDUCTIBLE AMOUNT PER BENEFIT  
9 PERIOD.

10 (C) SKILLED NURSING FACILITY CARE: COVERAGE FOR THE ACTUAL  
11 BILLED CHARGES UP TO THE COINSURANCE AMOUNT FROM THE TWENTY-FIRST  
12 DAY THROUGH THE ONE HUNDREDTH DAY IN A MEDICARE BENEFIT PERIOD  
13 FOR POSTHOSPITAL SKILLED NURSING FACILITY CARE ELIGIBLE UNDER  
14 MEDICARE PART A.

15 (D) MEDICARE PART B DEDUCTIBLE: COVERAGE FOR 100% OF THE  
16 MEDICARE PART B DEDUCTIBLE AMOUNT PER CALENDAR YEAR REGARDLESS OF  
17 HOSPITAL CONFINEMENT.

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

23 (F) MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY:  
24 COVERAGE TO THE EXTENT NOT COVERED BY MEDICARE FOR 80% OF THE  
25 BILLED CHARGES FOR MEDICARE-ELIGIBLE EXPENSES FOR MEDICALLY  
26 NECESSARY EMERGENCY HOSPITAL, PHYSICIAN, AND MEDICAL CARE  
27 RECEIVED IN A FOREIGN COUNTRY, WHICH CARE WOULD HAVE BEEN COVERED

1 BY MEDICARE IF PROVIDED IN THE UNITED STATES AND WHICH CARE BEGAN  
2 DURING THE FIRST 60 CONSECUTIVE DAYS OF EACH TRIP OUTSIDE THE  
3 UNITED STATES, SUBJECT TO A CALENDAR YEAR DEDUCTIBLE OF \$250.00,  
4 AND A LIFETIME MAXIMUM BENEFIT OF \$50,000.00. FOR PURPOSES OF  
5 THIS BENEFIT, "EMERGENCY CARE" MEANS CARE NEEDED IMMEDIATELY  
6 BECAUSE OF AN INJURY OR AN ILLNESS OF SUDDEN AND UNEXPECTED  
7 ONSET.

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

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

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

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

27       (5) A medicare supplement insurance benefit plan shall

1 conform to 1 of the following:

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

5 (b) A standardized medicare supplement benefit plan B shall  
6 include only the following: the core benefits as defined in  
7 section 3807 and the medicare part A deductible as defined in  
8 section 3809(1)(a).

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

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

21 (e) A standardized medicare supplement benefit plan E shall  
22 include only the following: the core benefits as defined in  
23 section 3807, the medicare part A deductible, skilled nursing  
24 facility care, medically necessary emergency care in a foreign  
25 country, and preventive medical care as defined in section  
26 3809(1)(a), (b), (h), and (i).

27 (f) A standardized medicare supplement benefit plan F shall

1 include only the following: the core benefits as defined in  
2 section 3807, the medicare part A deductible, skilled nursing  
3 facility care, medicare part B deductible, 100% of the medicare  
4 part B excess charges, and medically necessary emergency care in  
5 a foreign country as defined in section 3809(1)(a), (b), (c),  
6 (e), and (h). A standardized medicare supplement plan F high  
7 deductible shall include only the following: 100% of covered  
8 expenses following the payment of the annual high deductible plan  
9 F deductible. The covered expenses include the core benefits as  
10 defined in section 3807, plus the medicare part A deductible,  
11 skilled nursing facility care, the medicare part B deductible,  
12 100% of the medicare part B excess charges, and medically  
13 necessary emergency care in a foreign country as defined in  
14 section 3809(1)(a), (b), (c), (e), and (h). The annual high  
15 deductible plan F deductible shall consist of out-of-pocket  
16 expenses, other than premiums, for services covered by the  
17 medicare supplement plan F policy, and shall be in addition to  
18 any other specific benefit deductibles. The annual high  
19 deductible plan F deductible is \$1,790.00 for calendar year 2006,  
20 and the secretary shall adjust it annually thereafter to reflect  
21 the change in the consumer price index for all urban consumers  
22 for the 12-month period ending with August of the preceding year,  
23 rounded to the nearest multiple of \$10.00.

24 (g) A standardized medicare supplement benefit plan G shall  
25 include only the following: the core benefits as defined in  
26 section 3807, the medicare part A deductible, skilled nursing  
27 facility care, 80% of the medicare part B excess charges,

1 medically necessary emergency care in a foreign country, and the  
2 at-home recovery benefit as defined in section 3809(1)(a), (b),  
3 (d), (h), and (j).

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

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

21 (j) A standardized medicare supplement benefit plan J shall  
22 include only the following: the core benefits as defined in  
23 section 3807, the medicare part A deductible, skilled nursing  
24 facility care, medicare part B deductible, 100% of the medicare  
25 part B excess charges, extended outpatient prescription drug  
26 benefit, medically necessary emergency care in a foreign country,  
27 preventive medical care, and at-home recovery benefit as defined

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

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

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

27 (6) **THIS SECTION APPLIES TO MEDICARE SUPPLEMENT POLICIES OR**

1 CERTIFICATES DELIVERED OR ISSUED FOR DELIVERY ON OR AFTER JUNE 2,  
2 1992 WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010.

3 SEC. 3811A. (1) THIS SECTION APPLIES TO ALL MEDICARE  
4 SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR ISSUED FOR  
5 DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1,  
6 2010. A POLICY OR CERTIFICATE SHALL NOT BE ADVERTISED, SOLICITED,  
7 DELIVERED, OR ISSUED FOR DELIVERY IN THIS STATE AS A MEDICARE  
8 SUPPLEMENT POLICY OR CERTIFICATE UNLESS IT COMPLIES WITH THESE  
9 BENEFIT STANDARDS. BENEFIT PLAN STANDARDS APPLICABLE TO MEDICARE  
10 SUPPLEMENT POLICIES AND CERTIFICATES ISSUED BEFORE JUNE 1, 2010  
11 REMAIN SUBJECT TO THE REQUIREMENTS OF SECTION 3811.

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

1           (v) SKILLED NURSING FACILITY CARE: COVERAGE FOR 50% OF THE  
2 COINSURANCE AMOUNT FOR EACH DAY USED FROM THE TWENTY-FIRST DAY  
3 THROUGH THE ONE HUNDREDTH DAY IN A MEDICARE BENEFIT PERIOD FOR  
4 POSTHOSPITAL SKILLED NURSING FACILITY CARE ELIGIBLE UNDER  
5 MEDICARE PART A UNTIL THE OUT-OF-POCKET LIMITATION IS MET AS  
6 DESCRIBED IN SUBPARAGRAPH (x) .

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

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

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

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

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

1 INDEXED EACH YEAR BY THE APPROPRIATE INFLATION ADJUSTMENT  
2 SPECIFIED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF  
3 HEALTH AND HUMAN SERVICES.

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

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

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

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

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

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

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

26 (ii) THE LESSER OF \$50.00 OR THE MEDICARE PART B COINSURANCE  
27 OR COPAYMENT FOR EACH COVERED EMERGENCY ROOM VISIT. THE COPAYMENT

1 SHALL BE WAIVED IF THE INSURED IS ADMITTED TO ANY HOSPITAL AND  
2 THE EMERGENCY VISIT IS SUBSEQUENTLY COVERED AS A MEDICARE PART A  
3 EXPENSE.

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

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

- 24 (a) A cover page.  
25 (b) Premium information.  
26 (c) Disclosure pages.  
27 (d) Charts displaying the features of each benefit plan

1 offered by the insurer.

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

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

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

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

1 and in substantially the following form, as approved by the  
 2 commissioner:

3 \_\_\_\_\_(Insurer Name)  
 4 \_\_\_\_\_Medicare Supplement Coverage  
 5 \_\_\_\_\_Outline of Medicare Supplement Coverage Cover Page:  
 6 Benefit Plan(s) \_\_\_\_\_[insert letter(s) of plan(s) being offered]

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

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

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

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

17 ~~Blood: First three pints of blood each year.~~

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

1	<del>At Home Recovery</del>				<del>x</del>			<del>x</del>		<del>x</del>	<del>x</del>
2											
3											
4											
5	<del>Preventive Care not covered by Medicare</del>					<del>x</del>					<del>x</del>

6 \_\_\_\_\_ [COMPANY NAME]

7 ~~Outline of Medicare Supplement Coverage Cover Page 2~~

8 ~~Basic Benefits for Plans K and L include similar services as~~

9 ~~plans A J, but cost sharing for the basic benefits is at~~

10 ~~different levels.~~

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



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

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

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

26 ~~Once you reach the annual limit, the plan pays 100% of the Medicare~~

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

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

8 See Outlines of Coverage for details and exceptions.

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

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

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

16 **BASIC BENEFITS:**

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

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

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

24 **HOSPICE: PART A COINSURANCE**

1	A	B	C	D	F   F*	G
2	BASIC,	BASIC,	BASIC,	BASIC,	BASIC,	BASIC,
3	INCLUDING	INCLUDING	INCLUDING	INCLUDING	INCLUDING	INCLUDING
4	100% PART	100% PART	100% PART	100% PART	100% PART	100% PART
5	B COIN-	B COINSUR-	B COINSUR-	B COINSUR-	B COINSUR-	B COINSUR-
6	SURANCE	ANCE	ANCE	ANCE	ANCE	ANCE
7			SKILLED	SKILLED	SKILLED	SKILLED
8			NURSING	NURSING	NURSING	NURSING
9			FACILITY	FACILITY	FACILITY	FACILITY
10			COINSUR-	COINSUR-	COINSUR-	COINSUR-
11			ANCE	ANCE	ANCE	ANCE
12		PART A	PART A	PART A	PART A	PART A
13		DEDUCTIBLE	DEDUCTIBLE	DEDUCTIBLE	DEDUCTIBLE	DEDUCTIBLE
14			PART B		PART B	
15			DEDUCTIBLE		DEDUCTIBLE	
16					PART B	PART B
17					EXCESS	EXCESS
18					(100%)	(100%)
19			FOREIGN	FOREIGN	FOREIGN	FOREIGN
20			TRAVEL	TRAVEL	TRAVEL	TRAVEL
21			EMERGENCY	EMERGENCY	EMERGENCY	EMERGENCY
22	K	L	M	N		
23	HOSPITALIZATION	HOSPITALIZATION	BASIC,	BASIC, INCLUD-		
24	AND PREVENTIVE	AND PREVENTIVE	INCLUDING 100%	ING 100% PART B		
25	CARE PAID AT	CARE PAID AT	PART B	COINSURANCE,		
26	100%; OTHER	100%; OTHER	COINSURANCE	EXCEPT UP TO		
27	BASIC BENEFITS	BASIC BENEFITS		\$20 COPAYMENT		
28	PAID AT 50%	PAID AT 75%		FOR OFFICE		
29				VISIT, AND UP		

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

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

1 **TRAVEL EMERGENCY DEDUCTIBLE.**

2 PREMIUM INFORMATION

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

7 DISCLOSURES

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

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

15 READ YOUR POLICY VERY CAREFULLY

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

20 RIGHT TO RETURN POLICY

21 If you find that you are not satisfied with your policy, you

1 may return it to (insert insurer's address). If you send the  
2 policy back to us within 30 days after you receive it, we will  
3 treat the policy as if it had never been issued and return all of  
4 your payments.

5 POLICY REPLACEMENT

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

9 NOTICE

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

11 [For agent issued policies]

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

14 [For direct response issued policies]

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

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

19 COMPLETE ANSWERS ARE VERY IMPORTANT

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

1 important medical information. [If the policy or certificate is  
 2 guaranteed issue, this paragraph need not appear.]

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

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

16 PLAN A

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

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

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

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



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

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

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

26 **\*Once you have been billed ~~\$124~~ \$131 of Medicare-Approved**  
 27 **amounts for covered services (which are noted with an asterisk),**

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

2

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

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

7

## PARTS A &amp; B

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

22

## PLAN B

23

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

24

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

25

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

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

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

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

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

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

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

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

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

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

14 PARTS A & B

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

1	Approved Amounts	80%	20%	\$0
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2 PLAN C  
 3 MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

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

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



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

1 TERMINAL ILLNESS

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

9 PLAN C

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

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

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

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

23 PARTS A & B

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

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

11 OTHER BENEFITS—NOT COVERED BY MEDICARE

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

## PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but <del>\$952</del> <b>\$992</b>	<del>\$952</del> <b>\$992</b> (Part A Deductible)	\$0
61st thru 90th day	All but <del>\$238</del> <b>\$248</b> a day	<del>\$238</del> <b>\$248</b> a day	\$0
91st day and after —While using 60 lifetime reserve days	All but <del>\$476</del> <b>\$496</b> a day	<del>\$476</del> <b>\$496</b> a day	\$0
—Once lifetime reserve days are used: —Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
—Beyond the			

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

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

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

7 PLAN D

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

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

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

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

20 PARTS A & B

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



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

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

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

18 ~~PLAN E~~

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

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

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

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

19 ~~PLAN E~~

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

21 ~~\*Once you have been billed \$124 of Medicare Approved amounts~~

22 ~~for covered services (which are noted with an asterisk), your~~

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

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

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

1 ~~———— PARTS A & B~~

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

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

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

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

29

PLAN F OR HIGH DEDUCTIBLE PLAN F

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

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

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

14 15 16 17 18	SERVICES	MEDICARE PAYS	AFTER YOU PAY <del>\$1,790</del> <b>\$1,860</b> DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO <del>\$1,790</del> <b>\$1,860</b> DEDUCTIBLE**, YOU PAY
19 20 21 22 23 24 25 26 27	HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day	All but <del>\$952</del> <b>\$992</b> All but <del>\$238</del>	<del>\$952</del> <b>\$992</b> (Part A Deductible) <del>\$238</del> <b>\$248</b>	\$0 \$0



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

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

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

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

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

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

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

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

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

14

## PARTS A &amp; B

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

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

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

18 PLAN G

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

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

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

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

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

28

PLAN G

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

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

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



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

11

## PARTS A &amp; B

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

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

23 OTHER BENEFITS—NOT COVERED BY MEDICARE

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

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

11 ~~PLAN H~~

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

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

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

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

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

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

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

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

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

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

21 ~~PARTS A & B~~

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

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

9 ~~OTHER BENEFITS NOT COVERED BY MEDICARE~~

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

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

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

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

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

15 ~~any other facility for 60 days in a row.~~

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



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

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

8 ~~\_\_\_\_\_ PLAN I~~

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

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

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

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

20 ~~————— PARTS A & B~~

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

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

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

3	<del>FOREIGN TRAVEL-</del>			
4	<del>Not covered by Medicare</del>			
5	<del>Medically necessary</del>			
6	<del>emergency care services</del>			
7	<del>beginning during the</del>			
8	<del>first 60 days of each</del>			
9	<del>trip outside the USA</del>			
10	<del>First \$250 each</del>			
11	<del>calendar year</del>	<del>\$0</del>	<del>\$0</del>	<del>\$250</del>
12	<del>Remainder of Charges*</del>	<del>\$0</del>	<del>80% to a</del>	<del>20% and</del>
13			<del>lifetime</del>	<del>amounts</del>
14			<del>maximum</del>	<del>over the</del>
15			<del>benefit</del>	<del>\$50,000</del>
16			<del>of \$50,000</del>	<del>lifetime</del>
17				<del>maximum</del>
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3 ~~PLAN J OR HIGH DEDUCTIBLE PLAN J~~  
 4 ~~MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD~~  
 5 ~~\*A benefit period begins on the first day you receive~~  
 6 ~~service as an inpatient in a hospital and ends after you have~~  
 7 ~~been out of the hospital and have not received skilled care in~~  
 8 ~~any other facility for 60 days in a row.~~  
 9 ~~\*\*This high deductible plan pays the same benefits as plan J~~  
 10 ~~after you have paid a calendar year (\$1,790) deductible. Benefits~~  
 11 ~~from the high deductible plan J will not begin until out of~~  
 12 ~~pocket expenses are \$1,790. Out of pocket expenses for this~~  
 13 ~~deductible are expenses that would ordinarily be paid by the~~  
 14 ~~policy. This includes medicare deductibles for part A and part B,~~  
 15 ~~but does not include the plan's outpatient prescription drug~~  
 16 ~~deductible or separate foreign travel emergency deductible.~~

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

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

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

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

13 ~~PLAN J~~

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

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

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



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

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

18 \_\_\_\_\_ PARTS A & B

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

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

1 ~~OTHER BENEFITS NOT COVERED BY MEDICARE~~

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

1 PLAN K

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

13 PLAN K

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

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

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

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

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

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

1 the balance based on any difference between its billed charges  
 2 and the amount Medicare would have paid.

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

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

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



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

29           \*This plan limits your annual out-of-pocket payments for  
30 Medicare-approved amounts to ~~\$4,000~~**\$4,140** per year. However, this

1 limit does NOT include charges from your provider that exceed  
 2 Medicare-approved amounts (these are called "Excess Charges") and  
 3 you will be responsible for paying this difference in the amount  
 4 charged by your provider and the amount paid by Medicare for the  
 5 item or service.

6 PARTS A & B

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

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

23 PLAN L

24 \*You will pay one-fourth of the cost-sharing of some covered

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

11 PLAN L

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

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

17	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
18	HOSPITALIZATION**			
19	Semiprivate room and			
20	board, general nursing			
21	and miscellaneous			
22	services and supplies			
23	First 60 days	All but <del>\$952</del>	<del>\$714</del> <b>\$744</b>	<del>\$238</del> <b>\$248</b>
24		<b>\$992</b>	(75% of	(25% of
25			Part A	Part A
26			Deducti-	Deductible)
				1

1			ble)	
2	61st thru 90th day	All but <del>\$238</del>	<del>\$238</del> <b>\$248</b>	\$0
3		<b>\$248</b> a day	a day	
4	91st day and after:			
5	-While using 60			
6	lifetime reserve days	All but <del>\$476</del>	<del>\$476</del> <b>\$496</b>	\$0
7		<b>\$496</b> a day	a day	
8	-Once lifetime reserve			
9	days are used:			
10	-Additional 365 days	\$0	100% of	\$0***
11			Medicare	
12			Eligible	
13			Expenses	
14	-Beyond the			
15	Additional 365 days	\$0	\$0	All Costs
16	SKILLED NURSING FACILITY			
17	CARE**			
18	You must meet Medicare's			
19	requirements, including			
20	having been in a hospital			
21	for at least 3 days and			
22	entered a Medicare-			
23	approved facility within			
24	30 days after leaving the			
25	hospital			
26	First 20 days	All approved		
27		amounts	\$0	\$0
28	21st thru 100th day	All but	Up to	Up to
29		<del>\$119</del> <b>\$124</b> a	<del>\$89.25</del> <b>\$93</b>	<del>\$29.75</del> <b>\$31</b>
30		day	a day	a day 1
31	101st day and after	\$0	\$0	All costs



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

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

5	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
6	MEDICAL EXPENSES—			
7	In or out of the hospital			
8	and outpatient hospital			
9	treatment, such as			
10	Physician's services,			
11	inpatient and outpatient			
12	medical and surgical			
13	services and supplies,			
14	physical and speech			
15	therapy, diagnostic			
16	tests, durable medical			
17	equipment,			
18	First <del>\$124</del> <b>\$131</b> of			
19	Medicare Approved	\$0	\$0	<del>\$124</del> <b>\$131</b>
20	Amounts****			(Part
21				B Deducti-
22				ble)**** 1
23	Preventive Benefits for	Generally 75%	Remainder	All costs
24	Medicare covered	or more of	of Medi-	above Medi-
25	services	Medicare	care	care
26		approved	approved	approved
27		amounts	amounts	amounts
28	Remainder of Medicare	Generally	Generally	Generally

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

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

1

PARTS A & B

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

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

19

PLAN M

20

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

21

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

22

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

23

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

24

ANY OTHER FACILITY FOR 60 DAYS IN A ROW.

25

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

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

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

27   PLAN M  
 28               MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

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

4	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, SUCH AS PHYSICIAN'S SERVICES, INPATIENT AND OUTPATIENT MEDICAL AND SURGICAL SERVICES AND SUPPLIES, PHYSICAL AND SPEECH THERAPY, DIAGNOSTIC TESTS, DURABLE MEDICAL EQUIPMENT FIRST \$131 OF MEDICARE APPROVED AMOUNTS* REMAINDER OF MEDICARE APPROVED AMOUNTS	\$0 GENERALLY 80%	\$0 GENERALLY 20%	\$131 (PART B DEDUC- TIBLE) \$0
25 26 27	PART B EXCESS CHARGES (ABOVE MEDICARE APPROVED AMOUNTS)	\$0	\$0	ALL COSTS
28 29	BLOOD FIRST 3 PINTS	\$0	ALL COSTS	\$0

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

11 PARTS A & B

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

28 OTHER BENEFITS—NOT COVERED BY MEDICARE

29	FOREIGN TRAVEL—NOT			
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1	COVERED BY MEDICARE			
2	MEDICALLY NECESSARY			
3	EMERGENCY CARE SERVICES			
4	BEGINNING DURING THE			
5	FIRST 60 DAYS OF EACH			
6	TRIP OUTSIDE THE USA			
7	FIRST \$250 EACH			
8	CALENDAR YEAR	\$0	\$0	\$250
9	REMAINDER OF CHARGES	\$0	80% TO A	20% AND
10			LIFETIME	AMOUNTS
11			MAXIMUM	OVER THE
12			BENEFIT OF	\$50,000
13			\$50,000	LIFETIME
14				MAXIMUM

15 PLAN N

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

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

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

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

20 ANY OTHER FACILITY FOR 60 DAYS IN A ROW.

21	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
22	HOSPITALIZATION*			
23	SEMIPRIVATE ROOM AND			
24	BOARD, GENERAL NURSING			
25	AND MISCELLANEOUS			
26	SERVICES AND SUPPLIES			
27	FIRST 60 DAYS	ALL BUT \$992	\$992	\$0
28			(PART A	

1			DEDUC-	
2			TIBLE)	
3	61ST THRU 90TH DAY	ALL BUT \$248	\$248	\$0
4		A DAY	A DAY	
5	91ST DAY AND AFTER:			
6	-WHILE USING 60			
7	LIFETIME RESERVE DAYS	ALL BUT \$496	\$496	\$0
8		A DAY	A DAY	
9	-ONCE LIFETIME RESERVE			
10	DAYS ARE USED:			
11	-ADDITIONAL 365 DAYS	\$0	100% OF	\$0**
12			MEDICARE	
13			ELIGIBLE	
14			EXPENSES	
15	-BEYOND THE			
16	ADDITIONAL 365 DAYS	\$0	\$0	ALL COSTS
17	SKILLED NURSING FACILITY			
18	CARE*			
19	YOU MUST MEET MEDICARE'S			
20	REQUIREMENTS, INCLUDING			
21	HAVING BEEN IN A HOSPITAL			
22	FOR AT LEAST 3 DAYS AND			
23	ENTERED A MEDICARE-			
24	APPROVED FACILITY WITHIN			
25	30 DAYS AFTER LEAVING THE			
26	HOSPITAL			
27	FIRST 20 DAYS	ALL APPROVED	\$0	\$0
28		AMOUNTS		
29	21ST THRU 100TH DAY	ALL BUT \$124	UP TO \$124	\$0
30		A DAY	A DAY	
31	101ST DAY AND AFTER	\$0	\$0	ALL COSTS

1	BLOOD			
2	FIRST 3 PINTS	\$0	3 PINTS	\$0
3	ADDITIONAL AMOUNTS	100%	\$0	\$0
4	HOSPICE CARE			
5	YOU MUST MEET MEDICARE'S	ALL BUT VERY	MEDICARE	\$0
6	REQUIREMENTS, INCLUDING	LIMITED	COPAYMENT/	
7	A DOCTOR'S CERTIFICATION	COPAYMENT/	COINSURANCE	
8	OF TERMINAL ILLNESS	COINSURANCE		
9		FOR OUTPATIENT		
10		DRUGS AND		
11		INPATIENT		
12		RESPIRE CARE		

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

20   PLAN N  
 21           MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

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

25	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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1	MEDICAL EXPENSES—			
2	IN OR OUT OF THE			
3	HOSPITAL AND OUTPATIENT			
4	HOSPITAL TREATMENT, SUCH			
5	AS PHYSICIAN'S SERVICES,			
6	INPATIENT AND OUTPATIENT			
7	MEDICAL AND SURGICAL			
8	SERVICES AND SUPPLIES,			
9	PHYSICAL AND SPEECH			
10	THERAPY, DIAGNOSTIC			
11	TESTS, DURABLE MEDICAL			
12	EQUIPMENT			
13	FIRST \$131 OF MEDICARE			
14	APPROVED AMOUNTS*	\$0	\$0	\$131
15				(PART B
16				DEDUC-
17				TIBLE)
18	REMAINDER OF MEDICARE			
19	APPROVED AMOUNTS	GENERALLY	BALANCE,	UP TO \$20
20		80%	OTHER THAN	PER OFFICE
21			UP TO \$20	VISIT AND
22			PER OFFICE	UP TO \$50
23			VISIT AND	PER
24			UP TO \$50	EMERGENCY
25			PER	ROOM
26			EMERGENCY	VISIT. THE
27			ROOM VISIT.	COPAYMENT
28			THE	OF UP TO
29			COPAYMENT	\$50 IS
30			OF UP TO	WAIVED IF
31			\$50 IS	THE



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

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

15 OTHER BENEFITS—NOT COVERED BY MEDICARE

16	FOREIGN TRAVEL—NOT			
17	COVERED BY MEDICARE			
18	MEDICALLY NECESSARY			
19	EMERGENCY CARE SERVICES			
20	BEGINNING DURING THE			
21	FIRST 60 DAYS OF EACH			
22	TRIP OUTSIDE THE USA			
23	FIRST \$250 EACH			
24	CALENDAR YEAR	\$0	\$0	\$250
25	REMAINDER OF CHARGES	\$0	80% TO A	20% AND
26			LIFETIME	AMOUNTS
27			MAXIMUM	OVER THE
28			BENEFIT OF	\$50,000
29			\$50,000	LIFETIME
30				MAXIMUM

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

7           (2) The following standards apply to medicare supplement  
8 policies:

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

16           (b) A medicare supplement policy shall not indemnify against  
17 losses resulting from sickness on a different basis than losses  
18 resulting from accidents.

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

25           (d) A medicare supplement policy shall be guaranteed  
26 renewable. Termination shall be for nonpayment of premium or

1 material misrepresentation only.

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

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

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

20 (3) A medicare supplement policy shall provide that benefits  
21 and premiums under the policy shall be suspended at the request  
22 of the policyholder or certificate holder for a period not to  
23 exceed 24 months in which the policyholder or certificate holder  
24 has applied for and is determined to be entitled to medical  
25 assistance under medicaid, but only if the policyholder or  
26 certificate holder notifies the insurer of such assistance within  
27 90 days after the date the individual becomes entitled to the

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

27 (a) The reinstatement shall not provide for any waiting

1 period with respect to treatment of preexisting conditions.

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

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

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

20 (A) AN INSURER NEED NOT PROVIDE JUSTIFICATION TO THE  
21 COMMISSIONER IF THE INSURED REPLACES A 1990 STANDARDIZED POLICY  
22 OR CERTIFICATE WITH AN ISSUE AGE RATED 2010 STANDARDIZED POLICY  
23 OR CERTIFICATE AT THE INSURED'S ORIGINAL ISSUE AGE AND DURATION.  
24 IF AN INSURED'S POLICY OR CERTIFICATE TO BE REPLACED IS PRICED ON  
25 AN ISSUE AGE RATE SCHEDULE AT THAT TIME OF THAT OFFER, THE RATE  
26 CHARGED TO THE INSURED FOR THE NEW EXCHANGED POLICY SHALL  
27 RECOGNIZE THE POLICY RESERVE BUILDUP, DUE TO THE PREFUNDING

1 INHERENT IN THE USE OF AN ISSUE AGE RATE BASIS, FOR THE BENEFIT  
2 OF THE INSURED. THE METHOD PROPOSED TO BE USED BY AN ISSUER MUST  
3 BE FILED WITH THE COMMISSIONER.

4 (B) THE RATING CLASS OF THE NEW POLICY OR CERTIFICATE SHALL  
5 BE THE CLASS CLOSEST TO THE INSURED'S CLASS OF THE REPLACED  
6 COVERAGE.

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

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

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

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

25 (2) AN INSURANCE POLICY SHALL NOT BE TITLED, ADVERTISED,  
26 SOLICITED, OR ISSUED FOR DELIVERY IN THIS STATE AS A MEDICARE  
27 SUPPLEMENT POLICY IF THE POLICY DOES NOT MEET THE MINIMUM

1 STANDARDS PRESCRIBED IN THIS SECTION. THESE MINIMUM STANDARDS ARE  
2 IN ADDITION TO ALL OTHER REQUIREMENTS OF THIS CHAPTER. AN ISSUER  
3 SHALL NOT OFFER ANY 1990 PLAN FOR SALE ON OR AFTER JUNE 1, 2010.  
4 BENEFIT STANDARDS APPLICABLE TO MEDICARE SUPPLEMENT POLICIES AND  
5 CERTIFICATES ISSUED BEFORE JUNE 1, 2010 REMAIN SUBJECT TO THE  
6 REQUIREMENTS OF SECTION 3819.

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

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

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

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

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



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

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

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

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

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

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

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

1 HAVE APPLIED TO THE POLICYHOLDER OR CERTIFICATE HOLDER HAD THE  
2 COVERAGE NOT BEEN SUSPENDED.

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

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

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

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

1 medicare, written notice of the availability of coverage under  
2 this section.

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

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

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

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

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

27 (e) The insurer certifies to the commissioner that it is in

1 the process of discontinuing in Michigan its offering of  
2 individual or group expense incurred hospital, medical, or  
3 surgical policies or certificates.

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

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

19       (3) If an individual is a certificate holder in a group  
20 medicare supplement policy and the individual terminates  
21 membership in the group, the issuer shall offer the certificate  
22 holder the conversion opportunity described in subsection (2) **OR**  
23 (4) or at the option of the group policyholder, offer the  
24 certificate holder continuation of coverage under the group  
25 policy.

26       (4) If a group medicare supplement policy is replaced by  
27 another group medicare supplement policy purchased by the same

1 policyholder, the succeeding issuer shall offer coverage to all  
2 persons covered under the old group policy on its date of  
3 termination. Coverage under the new policy shall not result in  
4 any exclusion for preexisting conditions that would have been  
5 covered under the group policy being replaced.

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