

**SUBSTITUTE FOR
HOUSE BILL NO. 6431**

A bill to amend 1956 PA 218, entitled
"The insurance code of 1956,"
by amending sections 2266, 3801, 3803, 3811a, 3813, 3815, 3819a,
3827, 3829, 3831, 3835, 3843, and 3847 (MCL 500.2266, 500.3801,
500.3803, 500.3811a, 500.3813, 500.3815, 500.3819a, 500.3827,
500.3829, 500.3831, 500.3835, 500.3843, and 500.3847), section
2266 as added by 2018 PA 205, sections 3801, 3803, 3815, and 3831
as amended and sections 3811a and 3819a as added by 2009 PA 220,
sections 3813, 3843, and 3847 as added by 1992 PA 84, sections
3827 and 3835 as amended by 2006 PA 462, and section 3829 as
amended by 2002 PA 304, and by adding section 3811b; and to
repeal acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 2266. (1) Subject to the requirements of this section,

1 a notice to a party or any other document that is required in an
2 insurance transaction or that is to serve as evidence of
3 insurance coverage may be delivered, stored, and presented by
4 electronic means if it meets ~~both of the following:~~

5 ~~—— (a) The~~ **THE** requirements of the uniform electronic
6 transactions act, 2000 PA 305, MCL 450.831 to 450.849.

7 ~~—— (b) For a health insurer, the requirements of section~~
8 ~~2236(9) (a) (ii) .~~

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

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

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

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26 delivery method and has not withdrawn consent.

27 (b) Before obtaining consent, the insurer provides the party

1 with a clear and conspicuous statement informing the party of all
2 of the following:

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

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

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

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

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

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

27 (5) After the party consents as provided in subsection (4),

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

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

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

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

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

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

26 (9) This section must not be construed to modify, limit, or
27 supersede the federal electronic signatures in global national

1 commerce act, 15 USC 7001 to 7031.

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

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

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

11 **(11) THIS SECTION DOES NOT APPLY TO A HEALTH INSURER OR**
12 **HEALTH MAINTENANCE ORGANIZATION.**

13 **(12)** ~~(11)~~As used in this section:

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

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

19 (ii) Both of the following:

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

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

27 (b) "Party" means a recipient of a notice or document

1 required as part of an insurance transaction and includes an
2 applicant, insured, policy holder, or annuity contract holder.

3 Sec. 3801. As used in this chapter:

4 (a) "Applicant" means:

5 (i) For an individual ~~medicare~~**MEDICARE** supplement policy,
6 the person who seeks to contract for benefits.

7 (ii) For a group ~~medicare~~**MEDICARE** supplement policy or
8 certificate, the proposed certificate holder.

9 (b) "Bankruptcy" means, ~~when~~**WITH RESPECT TO** a ~~medicare~~
10 **MEDICARE** advantage organization that is not an insurer, **THAT THE**
11 **ORGANIZATION** has filed, or has had filed against it, a petition
12 for declaration of bankruptcy and has ceased doing business in
13 this state.

14 (c) "Certificate" means any certificate delivered or issued
15 for delivery in this state under a group ~~medicare~~**MEDICARE**
16 supplement policy.

17 (d) "Certificate form" means the form on which ~~the~~**A**
18 certificate is delivered or issued for delivery by ~~the~~**AN**
19 insurer.

20 (e) "Continuous period of creditable coverage" means the
21 period during which an individual was covered by creditable
22 coverage, if during the period of the coverage the individual had
23 no breaks in coverage greater than 63 days.

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

26 (i) A group health plan.

27 (ii) Health insurance coverage.

(iii) Part A or part B of ~~medicare~~. **MEDICARE**.

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

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

(vi) A medical care program of the Indian ~~health service~~ **HEALTH SERVICE** or of a tribal organization.

(vii) A state health benefits risk pool.

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

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

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

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

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

(i) "Insolvency" means, ~~when~~ **WITH RESPECT TO** an insurer licensed to transact the business of insurance in this state, **THAT THE INSURER** has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the insurer's state of domicile.

(j) "Insurer" includes any ~~entity, including a health care corporation operating pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704,~~ delivering **PERSON THAT DELIVERS** or issuing **ISSUES** for delivery in this state ~~medicare~~ **MEDICARE** supplement policies.

(k) "Medicaid" means ~~title~~ **SUBCHAPTER** XIX of the social security act, 42 USC 1396 to ~~1396v.~~ **1396W-5.**

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

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

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

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

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

(n) "Medicare supplement buyer's guide" means the document entitled, ~~"guide to health insurance for people with medicare",~~ **"CHOOSING A MEDIGAP POLICY: A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE"**, developed by the ~~national association of insurance commissioners~~ **NATIONAL ASSOCIATION OF INSURANCE**

~~1 COMMISSIONERS~~ and the United States ~~department of health and~~
~~2 human services~~ **DEPARTMENT OF HEALTH AND HUMAN SERVICES**, or a
 3 substantially similar document as approved by the
 4 ~~commissioner~~ **DIRECTOR**.

(o) "Medicare supplement policy" means an individual ~~7~~
~~6 nongroup~~, or group policy or certificate that is advertised,
 7 marketed, or designed primarily as a supplement to reimbursements
 8 under ~~medicare~~ **MEDICARE** for the hospital, medical, or surgical
 9 expenses of persons eligible for ~~medicare~~ **MEDICARE** and ~~medicare~~
 10 **MEDICARE** select policies and certificates under section 3817.
 11 Medicare supplement policy does not include a policy,
 12 certificate, or contract of 1 or more employers or labor
 13 organizations, or of the trustees of a fund established by 1 or
 14 more employers or labor organizations, or both, for employees or
 15 former employees, or both, or for members or former members, or
 16 both, of the labor organizations. Medicare supplement policy does
 17 not include ~~medicare~~ **MEDICARE** advantage plans established under
 18 ~~medicare~~ **MEDICARE** part C, outpatient prescription drug plans
 19 established under ~~medicare~~ **MEDICARE** part D, or any health care
 20 prepayment plan that provides benefits pursuant to an agreement
 21 under ~~section 1833(a)(1)(A) of the social security act~~ **42 USC**
 22 **1395l(A)(1)**.

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

(q) "Prestandardized ~~medicare~~ **MEDICARE** supplement benefit
 26 plan", "prestandardized benefit plan", or "prestandardized plan"
 27 means a group or individual policy of ~~medicare~~ **MEDICARE**

1 supplement insurance issued ~~prior to~~ **BEFORE** June 2, 1992.

2 (r) "1990 standardized ~~medicare~~ **MEDICARE** supplement benefit
3 plan", "1990 standardized benefit plan", or "1990 plan" means a
4 group or individual policy of ~~medicare~~ **MEDICARE** supplement
5 insurance issued on or after June 2, 1992 with an effective date
6 for coverage ~~prior to~~ **BEFORE** June 1, 2010 and includes ~~medicare~~
7 **MEDICARE** supplement insurance policies and certificates renewed
8 on or after that date ~~which~~ **THAT** are not replaced by the issuer
9 at the request of the insured.

10 (s) "2010 standardized ~~medicare~~ **MEDICARE** supplement benefit
11 plan", "2010 standardized benefit plan", or "2010 plan" means a
12 group or individual policy of ~~medicare~~ **MEDICARE** supplement
13 insurance with an effective date for coverage on or after June 1,
14 2010.

15 (t) "Policy form" means the form on which the policy or
16 certificate is delivered or issued for delivery by the insurer.

17 (u) "Secretary" means the secretary of the United States
18 ~~department of health and human services.~~ **DEPARTMENT OF HEALTH AND**
19 **HUMAN SERVICES.**

20 (v) "Social security act" means the social security act, 42
21 USC 301 to ~~1397jj.~~ **1397MM.**

22 Sec. 3803. (1) Except as provided in subsections (2) and
23 (3), this chapter applies to a ~~medicare~~ **MEDICARE** supplement
24 policy delivered, issued for delivery, or renewed in this state.

25 (2) Sections 3807, 3809, 3811, and 3819 apply to a ~~medicare~~
26 **MEDICARE** supplement policy delivered or issued for delivery in
27 this state on or after June 2, 1992 with an effective date for

1 coverage ~~prior to~~ **BEFORE** June 1, 2010.

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

6 Sec. 3811a. (1) This section applies to all ~~medicare~~
7 **MEDICARE** supplement policies or certificates delivered or issued
8 for delivery with an effective date for coverage on or after June
9 1, 2010. A policy or certificate ~~shall~~ **MUST** not be advertised,
10 solicited, delivered, or issued for delivery in this state as a
11 ~~medicare~~ **MEDICARE** supplement policy or certificate unless it
12 complies with these benefit standards. Benefit plan standards
13 applicable to ~~medicare~~ **MEDICARE** supplement policies and
14 certificates issued before June 1, 2010 remain subject to the
15 requirements of section 3811.

16 (2) An insurer shall make available to each prospective
17 ~~medicare~~ **MEDICARE** supplement policyholder and certificate holder
18 a policy form or certificate form containing only the basic core
19 benefits as provided in section 3807a. If an insurer makes
20 available any of the additional benefits described in section
21 3809a or offers standardized benefit plans K or L, the insurer
22 shall make available to each prospective ~~medicare~~ **MEDICARE**
23 supplement policyholder and certificate holder a policy form or
24 certificate form containing either standardized benefit plan C or
25 standardized benefit plan F.

26 (3) Groups, packages, or combinations of ~~medicare~~ **MEDICARE**
27 supplement benefits other than those listed in this section ~~shall~~

1 **MUST** not be offered for sale in this state except as may be
2 permitted in subsection (6)(k).

3 (4) Benefit plans ~~shall~~**MUST** be uniform in structure,
4 language, designation, and format to the standard benefit plans
5 in subsection (6) and ~~shall~~**MUST** conform to the definitions in
6 this chapter. Each benefit ~~shall~~**MUST** be structured in accordance
7 with sections 3807a and 3809a and list the benefits in the order
8 shown in subsection (6). ~~For purposes of~~ **AS USED IN** this section,
9 "structure, language, **DESIGNATION**, and format" means style,
10 arrangement, and overall content of a benefit.

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

14 (6) A ~~medicare~~**MEDICARE** supplement insurance benefit plan
15 ~~shall~~**MUST** conform to 1 of the following:

16 (a) A standardized ~~medicare~~**MEDICARE** supplement benefit plan
17 A ~~shall~~**MUST** be limited to the basic core benefits common to all
18 benefit plans as ~~defined in~~ **REQUIRED UNDER** section 3807a.

19 (b) A standardized ~~medicare~~**MEDICARE** supplement benefit plan
20 B ~~shall~~**MUST** include only the following: the core benefits as
21 ~~defined in~~ **REQUIRED UNDER** section 3807a and 100% of the ~~medicare~~
22 **MEDICARE** part A deductible as defined in section 3809a(2)(a).

23 (c) A standardized ~~medicare~~**MEDICARE** supplement benefit plan
24 C ~~shall~~**MUST** include only the following: the core benefits as
25 ~~defined in~~ **REQUIRED UNDER** section 3807a ~~, AND~~ 100% of the
26 ~~medicare~~**MEDICARE** part A deductible, skilled nursing facility
27 care, 100% of the ~~medicare~~**MEDICARE** part B deductible, and

1 medically necessary emergency care in a foreign country as
 2 defined in section 3809a(2)(a), (c), (d), and (f).

3 (d) A standardized ~~medicare~~**MEDICARE** supplement benefit plan
 4 ~~D shall~~**MUST** include only the following: the core benefits as
 5 ~~defined in~~**REQUIRED UNDER** section 3807a ~~, AND~~ 100% of the
 6 ~~medicare~~**MEDICARE** part A deductible, skilled nursing facility
 7 care, and medically necessary emergency care in a foreign country
 8 as defined in section 3809a(2)(a), (c), and (f).

9 (e) A standardized ~~medicare~~**MEDICARE** supplement benefit plan
 10 ~~F shall~~**MUST** include only the following: the core benefits as
 11 ~~defined in~~**REQUIRED UNDER** section 3807a ~~, AND~~ 100% of the
 12 ~~medicare~~**MEDICARE** part A deductible, skilled nursing facility
 13 care, 100% of the ~~medicare~~**MEDICARE** part B deductible, 100% of
 14 the ~~medicare~~**MEDICARE** part B excess charges, and medically
 15 necessary emergency care in a foreign country as defined in
 16 section 3809a(2)(a), (c), (d), (e), and (f). A standardized
 17 ~~medicare~~**MEDICARE** supplement plan F high deductible ~~shall~~**MUST**
 18 include only the following: 100% of covered expenses following
 19 the payment of the annual ~~high deductible~~**HIGH-DEDUCTIBLE** plan F
 20 deductible. The covered expenses include the core benefits as
 21 ~~defined in~~**REQUIRED UNDER** section 3807a ~~, plus~~**AND** 100% of the
 22 ~~medicare~~**MEDICARE** part A deductible, skilled nursing facility
 23 care, 100% of the ~~medicare~~**MEDICARE** part B deductible, 100% of
 24 the ~~medicare~~**MEDICARE** part B excess charges, and medically
 25 necessary emergency care in a foreign country as defined in
 26 section 3809a(2)(a), (c), (d), (e), and (f). The annual ~~high~~
 27 ~~deductible~~**HIGH-DEDUCTIBLE** plan F deductible ~~shall~~**MUST** consist

1 of out-of-pocket expenses, other than premiums, for services
 2 covered by the ~~medicare~~**MEDICARE** supplement plan F policy, and
 3 ~~shall~~**MUST** be in addition to any other specific benefit
 4 deductibles. The annual ~~high deductible~~**HIGH-DEDUCTIBLE** plan F
 5 deductible is \$1,500.00 for calendar year 1999, and the secretary
 6 shall adjust it annually thereafter to reflect the change in the
 7 ~~consumer price index~~**CONSUMER PRICE INDEX** for all urban consumers
 8 for the 12-month period ending with August of the preceding year,
 9 rounded to the nearest multiple of \$10.00.

10 (f) A standardized ~~medicare~~**MEDICARE** supplement benefit plan
 11 G ~~shall~~**MUST** include only the following: the core benefits as
 12 ~~defined in~~**REQUIRED UNDER** section 3807a ~~, AND~~ 100% of the
 13 ~~medicare~~**MEDICARE** part A deductible, skilled nursing facility
 14 care, 100% of the ~~medicare~~**MEDICARE** part B excess charges, and
 15 medically necessary emergency care in a foreign country as
 16 defined in section 3809a(2)(a), (c), (e), and (f). **EFFECTIVE**
 17 **JANUARY 1, 2020, THE STANDARDIZED PLAN F HIGH DEDUCTIBLE BENEFIT**
 18 **PLAN, REDESIGNATED IN SECTION 3811B(2)(D) AS PLAN G HIGH**
 19 **DEDUCTIBLE, MAY BE OFFERED TO AN INDIVIDUAL WHO WAS ELIGIBLE FOR**
 20 **MEDICARE BEFORE JANUARY 1, 2020.**

21 (g) Standardized ~~medicare~~**MEDICARE** supplement benefit plan K
 22 ~~shall~~**MUST** consist of the following:

23 (i) Coverage of 100% of the part A hospital coinsurance
 24 amount for each day used from the sixty-first day through the
 25 ninetieth day in any ~~medicare~~**MEDICARE** benefit period.

26 (ii) Coverage of 100% of the part A hospital coinsurance
 27 amount for each ~~medicare~~**MEDICARE** lifetime inpatient reserve day

1 used from the ninety-first day through the one hundred fiftieth
2 day in any ~~medicare~~**MEDICARE** benefit period.

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

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

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

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

25 (vii) Coverage for 50%, under ~~medicare~~**MEDICARE** part A or B,
26 of the reasonable cost of the first 3 pints of blood or
27 equivalent quantities of packed red blood cells, as defined under

1 federal regulations, unless replaced in accordance with federal
 2 regulations until the out-of-pocket limitation is met as
 3 described in subparagraph (x).

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

9 (ix) Coverage of 100% of the cost sharing for ~~medicare~~
 10 **MEDICARE** part B preventive services after the policyholder pays
 11 the part B deductible.

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

20 (h) Standardized ~~medicare~~ **MEDICARE** supplement benefit plan L
 21 ~~shall~~ **MUST** consist of the following:

22 (i) The benefits described in subdivision (g) (i), (ii), (iii),
 23 and (ix).

24 (ii) The benefits described in subdivision (g) (iv), (v), (vi),
 25 (vii), and (viii), but substituting 75% for 50%.

26 (iii) The benefit described in subdivision (g) (x), but
 27 substituting \$2,000.00 for \$4,000.00.

(i) A standardized ~~medicare~~**MEDICARE** supplement benefit plan ~~shall~~**MUST** include only the following: the core benefits as defined in ~~REQUIRED UNDER~~ section 3807a and 50% of the ~~medicare~~**MEDICARE** part A deductible, skilled nursing care, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(b), (c), and (f).

(j) A standardized ~~medicare~~**MEDICARE** supplement benefit plan ~~shall~~**MUST** include only the following: the core benefits as defined in ~~REQUIRED UNDER~~ section 3807a ~~, AND~~ 100% of the ~~medicare~~**MEDICARE** part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), and (f) with copayments in the following amounts:

(i) The lesser of \$20.00 or the ~~medicare~~**MEDICARE** part B coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists.

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

(k) New or innovative benefits: an insurer may, with the prior approval of the ~~commissioner~~**DIRECTOR**, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to ~~medicare~~

1 **MEDICARE** supplement insurance, new or innovative, not otherwise
 2 available, cost-effective, and offered in a manner that is
 3 consistent with the goal of simplification of ~~medicare~~**MEDICARE**
 4 supplement policies. The innovative benefit ~~shall~~**MUST** not
 5 include an outpatient prescription drug benefit. New or
 6 innovative benefits ~~shall~~**MUST** not be used to change or reduce
 7 benefits, including a change of any cost-sharing provision, in
 8 any standardized plan.

9 **SEC. 3811B. (1) THIS SECTION APPLIES TO ALL MEDICARE**
 10 **SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR ISSUED FOR**
 11 **DELIVERY IN THIS STATE TO INDIVIDUALS NEWLY ELIGIBLE FOR MEDICARE**
 12 **AFTER DECEMBER 31, 2019. A POLICY OR CERTIFICATE THAT PROVIDES**
 13 **COVERAGE OF THE MEDICARE PART B DEDUCTIBLE MUST NOT BE**
 14 **ADVERTISED, SOLICITED, DELIVERED, OR ISSUED FOR DELIVERY IN THIS**
 15 **STATE AS A MEDICARE SUPPLEMENT POLICY OR CERTIFICATE TO**
 16 **INDIVIDUALS NEWLY ELIGIBLE FOR MEDICARE AFTER DECEMBER 31, 2019,**
 17 **UNLESS IT COMPLIES WITH THE BENEFIT STANDARDS PROVIDED IN THIS**
 18 **SECTION. BENEFIT PLAN STANDARDS APPLICABLE TO MEDICARE SUPPLEMENT**
 19 **POLICIES AND CERTIFICATES ISSUED TO INDIVIDUALS ELIGIBLE FOR**
 20 **MEDICARE BEFORE JANUARY 1, 2020 REMAIN SUBJECT TO THE**
 21 **REQUIREMENTS OF SECTION 3811A.**

22 **(2) THE STANDARDS AND REQUIREMENTS OF SECTION 3811A APPLY TO**
 23 **ALL MEDICARE SUPPLEMENT POLICIES OR CERTIFICATES DELIVERED OR**
 24 **ISSUED FOR DELIVERY TO INDIVIDUALS NEWLY ELIGIBLE FOR MEDICARE**
 25 **AFTER DECEMBER 31, 2019, WITH THE FOLLOWING EXCEPTIONS:**

26 **(A) STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN C IS**
 27 **REDESIGNATED AS PLAN D AND MUST PROVIDE THE BENEFITS CONTAINED IN**

1 SECTION 3811A(6) (C) , BUT MUST NOT PROVIDE COVERAGE FOR 100% OR
2 ANY PORTION OF THE MEDICARE PART B DEDUCTIBLE.

3 (B) STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN F IS
4 REDESIGNATED AS PLAN G AND MUST PROVIDE THE BENEFITS CONTAINED IN
5 SECTION 3811A(6) (E) , AS APPLICABLE, BUT MUST NOT PROVIDE COVERAGE
6 FOR 100% OR ANY PORTION OF THE MEDICARE PART B DEDUCTIBLE.

7 (C) STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLANS C, F, AND
8 F HIGH DEDUCTIBLE MAY NOT BE OFFERED TO INDIVIDUALS NEWLY
9 ELIGIBLE FOR MEDICARE AFTER DECEMBER 31, 2019.

10 (D) STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN F HIGH
11 DEDUCTIBLE IS REDESIGNATED AS PLAN G HIGH DEDUCTIBLE AND MUST
12 PROVIDE THE BENEFITS IN SECTION 3811A(6) (E) , AS APPLICABLE, BUT
13 MUST NOT PROVIDE COVERAGE FOR 100% OR ANY PORTION OF THE MEDICARE
14 PART B DEDUCTIBLE. THE MEDICARE PART B DEDUCTIBLE PAID BY THE
15 BENEFICIARY IS CONSIDERED AN OUT-OF-POCKET EXPENSE IN MEETING THE
16 ANNUAL HIGH DEDUCTIBLE.

17 (E) THE REFERENCE TO PLAN C OR PLAN F CONTAINED IN SECTION
18 3811A(2) IS DEEMED A REFERENCE TO PLAN D OR PLAN G, RESPECTIVELY,
19 FOR PURPOSES OF THIS SECTION.

20 (3) THIS SECTION ONLY APPLIES TO INDIVIDUALS THAT ARE NEWLY
21 ELIGIBLE FOR MEDICARE AFTER DECEMBER 31, 2019 BECAUSE OF EITHER
22 OF THE FOLLOWING:

23 (A) BY REASON OF ATTAINING AGE 65 AFTER DECEMBER 31, 2019.

24 (B) BY REASON OF ENTITLEMENT TO BENEFITS UNDER MEDICARE PART
25 A UNDER SECTION 226(B) OR 226A OF THE SOCIAL SECURITY ACT, OR WHO
26 IS DEEMED TO BE ELIGIBLE FOR BENEFITS UNDER SECTION 226A OF THE
27 SOCIAL SECURITY ACT AFTER DECEMBER 31, 2019.

(4) FOR PURPOSES OF SECTION 3830(5) TO (8), FOR AN INDIVIDUAL NEWLY ELIGIBLE FOR MEDICARE AFTER DECEMBER 31, 2019, ANY REFERENCE TO MEDICARE SUPPLEMENT POLICY OR CERTIFICATE PLANS C, F, OR F HIGH DEDUCTIBLE IS DEEMED TO BE A REFERENCE TO MEDICARE SUPPLEMENT POLICY OR CERTIFICATE PLANS D, G, OR G HIGH DEDUCTIBLE, RESPECTIVELY, THAT MEET THE REQUIREMENTS OF SUBSECTION (2).

(5) AFTER DECEMBER 31, 2019, THE STANDARDIZED BENEFIT PLANS DESCRIBED IN SUBSECTION (2) (D) MAY BE OFFERED TO AN INDIVIDUAL WHO WAS ELIGIBLE FOR MEDICARE BEFORE JANUARY 1, 2020, IN ADDITION TO THE STANDARDIZED PLANS DESCRIBED IN SECTION 3811A(6).

Sec. 3813. An insurer that issues a policy that provides ~~disability~~ **HEALTH INSURANCE** coverage to a person eligible for ~~medicare~~ **MEDICARE** by reason of age shall provide the prospective policyholder with a ~~medicare~~ **MEDICARE** supplement buyer's guide **IN WRITTEN OR ELECTRONIC FORMAT**, which ~~shall~~ **MUST** be furnished at the time of application, and **THE INSURER SHALL OBTAIN, IN WRITTEN OR ELECTRONIC FORMAT**, acknowledgment of receipt of the buyer's guide. ~~shall be obtained by the insurer.~~ However, for direct response solicitation policies, the guide ~~shall~~ **MUST** be furnished with the policy **IN WRITTEN OR ELECTRONIC FORMAT** and **THE INSURER NEED NOT OBTAIN** acknowledgment of receipt. ~~need not be obtained by the insurer.~~ This section does not apply to policies that provide accidental death benefits for travel or other accidents, or if the medical expense or indemnity payments are only incidental to the accidental death benefits for travel or other accidents.

1 Sec. 3815. (1) An insurer that offers a ~~medicare~~**MEDICARE**
2 supplement policy shall provide to the applicant at the time of
3 application an outline of coverage **IN WRITTEN OR ELECTRONIC**
4 **FORMAT** and, except for direct response solicitation policies,
5 shall obtain an acknowledgment of receipt of the outline of
6 coverage from the applicant **IN WRITTEN OR ELECTRONIC FORMAT**. The
7 outline of coverage provided to applicants ~~pursuant to~~**UNDER** this
8 section ~~shall~~**MUST** consist of the following 4 parts:

- 9 (a) A cover page.
10 (b) Premium information.
11 (c) Disclosure pages.
12 (d) Charts displaying the features of each benefit plan
13 offered by the insurer.

14 (2) Insurers shall comply with any notice requirements of
15 the ~~medicare~~**MEDICARE** prescription drug, improvement, and
16 modernization act of 2003, Public Law 108-173.

17 (3) If an outline of coverage is provided at the time of
18 application and the ~~medicare~~**MEDICARE** supplement policy or
19 certificate is issued on a basis that would require revision of
20 the outline, a substitute outline of coverage properly describing
21 the policy or certificate ~~shall~~**MUST** accompany the policy or
22 certificate when it is delivered and ~~shall~~**MUST** contain the
23 following statement, in ~~no~~**NOT** less than 12-point type,
24 immediately above the company name:

25 NOTICE: Read this outline of coverage carefully.

26 It is not identical to the outline of coverage

provided ~~upon~~**ON** application and the coverage
originally applied for has not been issued.

(4) An outline of coverage under subsection (1) ~~shall~~**MUST**
be in the language and **IN A WRITTEN OR ELECTRONIC** format
prescribed in this section and in not less than 12-point type.
The letter designation of the plan ~~shall~~**MUST** be shown on the
cover page and the plans offered by the insurer ~~shall~~**MUST** be
prominently identified. Premium information ~~shall~~**MUST** be shown
on the cover page or immediately following the cover page and
~~shall~~**MUST** be prominently displayed. The premium and method of
payment mode ~~shall~~**MUST** be stated for all plans that are offered
to the applicant. All possible premiums for the applicant ~~shall~~
MUST be illustrated. The following items ~~shall~~**MUST** be included
in the outline of coverage in the order prescribed below and in
substantially the following form, as approved by the
~~commissioner~~**DIRECTOR**:

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

This chart shows the benefits included in each of the
standard Medicare supplement plans. Every company must make Plan
"A" available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale. (This
sentence ~~shall~~**MUST** not appear after June 1, 2011.)

BASIC BENEFITS:

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

9	A	B	C**	D	F F* **	G/G*
10	Basic,	Basic,	Basic,	Basic,	Basic,	Basic,
11	including	including	including	including	including	including
12	100% Part	100% Part	100% Part	100% Part	100% Part	100% Part
13	B coin-	B coinsur-	B coinsur-	B coinsur-	B coinsur-	B coinsur-
14	surance	ance	ance	ance	ance	ance
15			Skilled	Skilled	Skilled	Skilled
16			Nursing	Nursing	Nursing	Nursing
17			Facility	Facility	Facility	Facility
18			Coinsur-	Coinsur-	Coinsur-	Coinsur-
19			ance	ance	ance	ance
20		Part A	Part A	Part A	Part A	Part A
21		Deductible	Deductible	Deductible	Deductible	Deductible
22			Part B		Part B	
23			Deductible		Deductible	
24					Part B	Part B
25					Excess	Excess
26					(100%)	(100%)
27			Foreign	Foreign	Foreign	Foreign

1			Travel	Travel	Travel	Travel
2			Emergency	Emergency	Emergency	Emergency

3

4	K	L	M	N
5	Hospitalization	Hospitalization	Basic,	Basic, includ-
6	and preventive	and preventive	including 100%	ing 100% Part B
7	care paid at	care paid at	Part B	coinsurance,
8	100%; other	100%; other	coinsurance	except up to
9	basic benefits	basic benefits		\$20 copayment
10	paid at 50%	paid at 75%		for office
11				visit, and up
12				to \$50 copay-
13				ment for ER
14	50% Skilled	75% Skilled	Skilled	Skilled
15	Nursing	Nursing	Nursing	Nursing
16	Facility	Facility	Facility	Facility
17	Coinsurance	Coinsurance	Coinsurance	Coinsurance
18	50% Part A	75% Part A	50% Part A	Part A
19	Deductible	Deductible	Deductible	Deductible
20				
21				
22			Foreign	Foreign
23			Travel	Travel
24			Emergency	Emergency
25	Out-of-pocket	Out-of-pocket		
26	limit \$4,140;	limit \$2,070;		
	\$5,240;	\$2,620;		
27	paid at 100%	paid at 100%		

1	after limit	after limit		
2	reached	reached		

3 * Plan ~~PLANS F AND G~~ also has an option ~~HAVE OPTIONS~~ called
4 a ~~high-deductible Plan F~~. ~~This~~ **AND HIGH-DEDUCTIBLE PLAN G. THESE**
5 high-deductible ~~plan pays~~ **PLANS PAY** the same benefits as Plan F
6 **OR PLAN G, AS APPLICABLE,** after one has paid a calendar year
7 ~~\$1,860~~ **\$2,240** deductible. Benefits from high-deductible Plan F **OR**
8 **HIGH-DEDUCTIBLE PLAN G** will not begin until out-of-pocket
9 expenses exceed ~~\$1,860~~. **\$2,240**. Out-of-pocket expenses for ~~this~~
10 ~~deductible~~ **THESE DEDUCTIBLES** are expenses that would ordinarily
11 be paid by the policy. These expenses include the Medicare
12 deductibles for Part A and Part B, but do not include the plan's
13 separate foreign travel emergency deductible.

14 ** PLAN C, PLAN F, AND HIGH-DEDUCTIBLE PLAN F ARE ONLY
15 AVAILABLE TO INDIVIDUALS ELIGIBLE FOR MEDICARE BEFORE JANUARY 1,
16 2020.

17 PREMIUM INFORMATION

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

22 DISCLOSURES

23 Use this outline to compare benefits and premiums among

1 policies, certificates, and contracts.

2 This outline shows benefits and premiums of policies sold
3 for effective dates on or after June 1, 2010. Policies sold for
4 effective dates ~~prior to~~ **BEFORE** June 1, 2010 have different
5 benefits and premiums. Plans E, H, I, and J are no longer
6 available for sale. (This sentence ~~shall~~ **MUST** not appear after
7 June 1, 2011.)

8 READ YOUR POLICY VERY CAREFULLY

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

13 RIGHT TO RETURN POLICY

14 If you find that you are not satisfied with your policy, you
15 may return it to (insert insurer's address). If you send the
16 policy back to us within 30 days after you receive it, we will
17 treat the policy as if it had never been issued and return all of
18 your payments.

19 POLICY REPLACEMENT

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

NOTICE

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

[For agent issued policies]

Neither (insert insurer's name) nor its agents are connected with ~~medicare~~. **MEDICARE**.

[For direct response issued policies]

(Insert insurer's name) is not connected with ~~medicare~~. **MEDICARE**.

This outline of coverage does not give all the details of ~~medicare~~ **MEDICARE** coverage. Contact your local social security office or consult ~~"the medicare handbook"~~ **"THE MEDICARE HANDBOOK"** for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

[Include for each plan offered by the insurer a chart showing the services, ~~medicare~~ **MEDICARE** payments, plan payments, and insured payments using the same language, in the same order, and using uniform layout and format as shown in the charts that

1 follow. An insurer may use additional benefit plan designations
 2 on these charts ~~pursuant to~~ **UNDER** section 3809(1)(k). Include an
 3 explanation of any innovative benefits on the cover page and in
 4 the chart, in a manner approved by the ~~commissioner.~~ **DIRECTOR.**
 5 The insurer issuing the policy shall change the dollar amounts
 6 each year to reflect current figures. No more than 4 plans may be
 7 shown on 1 chart.] Charts for each plan are as follows:

8 PLAN A

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

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

14	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
15	HOSPITALIZATION*			
16	Semiprivate room and			
17	board, general nursing			
18	and miscellaneous			
19	services and supplies			
20	First 60 days	All but	\$0	\$992 \$1,340
21		\$992 \$1,340		(Part A
22				Deductible)
23	61st thru 90th day	All but	\$248 \$335	\$0
24		\$248 \$335	a day	
25		a day		

1	91st day and after:			
2	-While using 60			
3	lifetime reserve days	All but	\$496 \$670	\$0
4		\$496 \$670	a day	
5		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 hospital			
19	for at least 3 days and			
20	entered a Medicare-			
21	approved facility within			
22	30 days after leaving the			
23	hospital			
24	First 20 days	All approved		
25		amounts	\$0	\$0
26	21st thru 100th day	All but	\$0	Up to
27		\$124 \$167.50		\$124 \$167.50
28		a day		a day
29	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	All but very		\$0
6	Medicare's requirements	limited	Medicare	
7	including a doctor's	copayment/	copayment/	
8	certification of terminal	coinsurance	coinsurance	
9	illness	for outpatient		
10		drugs and		
11		inpatient		
12		respite care		
13				

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

21 PLAN A

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

23 *Once you have been billed ~~\$131~~ **\$183** of Medicare-Approved
24 amounts for covered services (which are noted with an asterisk),
25 your Part B Deductible will have been met for the calendar year.

1	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
2	MEDICAL EXPENSES—			
3	In or out of the hospital			
4	and outpatient hospital			
5	treatment, such as			
6	Physician's services,			
7	inpatient and outpatient			
8	medical and surgical			
9	services and supplies,			
10	physical and speech			
11	therapy, diagnostic			
12	tests, durable medical			
13	equipment,			
14	First \$131 \$183 of			
15	Medicare Approved	\$0	\$0	\$131 \$183
16	Amounts*			(Part B
17				Deductible)
18	Remainder of Medicare			
19	Approved Amounts	80%	20%	\$0
20	Part B Excess Charges			
21	(Above Medicare			
22	Approved Amounts)	\$0	\$0	All Costs
23	BLOOD			
24	First 3 pints	\$0	All Costs	\$0
25	Next \$131 \$183 of			
26	Medicare	\$0	\$0	\$131 \$183
27	Approved Amounts*			(Part B
28				Deductible)
29	Remainder of Medicare			

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

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 \$131 \$183 of			
16	Medicare	\$0	\$0	\$131 \$183
17	Approved Amounts*			(Part B
18				Deductible)
19	Remainder of Medicare			
20	Approved Amounts	80%	20%	\$0

21 PLAN B

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

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

1 service as an inpatient in a hospital and ends after you have
 2 been out of the hospital and have not received skilled care in
 3 any other facility for 60 days in a row.

4	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
5	HOSPITALIZATION*			
6	Semiprivate room and			
7	board, general nursing			
8	and miscellaneous			
9	services and supplies			
10	First 60 days	All but	\$992 \$1,340	\$0
11		\$992 \$1,340	(Part A	
12			Deductible)	
13	61st thru 90th day	All but	\$248 \$335	\$0
14		\$248 \$335 a day	a day	
15	91st day and after			
16	-While using 60			
17	lifetime reserve days	All but	\$496 \$670	\$0
18		\$496 \$670 a day	a day	
19	-Once lifetime reserve			
20	days are used:			
21	-Additional 365 days	\$0	100% of	\$0**
22			Medicare	
23			Eligible	
24			Expenses	
25	-Beyond the			
26	Additional 365 days	\$0	\$0	All Costs
27	SKILLED NURSING FACILITY			
28	CARE*			

1	You must meet Medicare's			
2	requirements, including			
3	having been in a hospital			
4	for at least 3 days and			
5	entered a Medicare-			
6	approved facility within			
7	30 days after leaving the			
8	hospital			
9	First 20 days	All approved		
10		amounts	\$0	\$0
11	21st thru 100th day	All but	\$0	Up to
12		\$124 \$167.50		\$124
13				\$167.50
14		a day		a day
15	101st day and after	\$0	\$0	All costs
16	BLOOD			
17	First 3 pints	\$0	3 pints	\$0
18	Additional amounts	100%	\$0	\$0
19	HOSPICE CARE			
20		All but very		
21		limited	Medicare	\$0
22		copayment/	copayment/	
23		coinsurance	coinsurance	
24	You must meet	for outpatient		
25	Medicare's requirements,	drugs and		
26	including a doctor's	inpatient		
27	certification of	respite care		
28	terminal illness			

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

8 PLAN B

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

10 *Once you have been billed ~~\$131~~**\$183** of Medicare-Approved
11 amounts for covered services (which are noted with an asterisk),
12 your Part B Deductible will have been met for the calendar year.

	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
14	MEDICAL EXPENSES—			
15	In or out of the hospital			
16	and outpatient hospital			
17	treatment, such as			
18	Physician's services,			
19	inpatient and outpatient			
20	medical and surgical			
21	services and supplies,			
22	physical and speech			
23	therapy, diagnostic			
24	tests, durable medical			
25	equipment,			
26	First \$131—\$183 of			

1	Medicare Approved	\$0	\$0	\$131 \$183
2	Amounts*			(Part B
3				Deductible)
4	Remainder of Medicare			
5	Approved Amounts	80%	20%	\$0
6	Part B Excess Charges			
7	(Above Medicare			
8	Approved Amounts)	\$0	\$0	All Costs
9	BLOOD			
10	First 3 pints	\$0	All Costs	\$0
11	Next \$131 \$183 of Medicare			
12	Approved Amounts*	\$0	\$0	\$131 \$183
13				(Part B
14	Remainder of Medicare			Deductible)
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

1	-Durable medical			
2	equipment			
3	First \$131 \$183 of			
4	Medicare			
5	Approved Amounts*	\$0	\$0	\$131 \$183
6				(Part B
7				Deductible)
8	Remainder of Medicare			
9	Approved Amounts	80%	20%	\$0

10

PLAN C

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	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
17	HOSPITALIZATION*			
18	Semiprivate room and			
19	board, general nursing			
20	and miscellaneous			
21	services and supplies			
22	First 60 days	All but	\$992 \$1,340	\$0
23		\$992 \$1,340	(Part A	
24			Deductible)	
25	61st thru 90th day	All but	\$248 \$335	\$0

1		\$248 \$335 a day	a day	
2	91st day and after			
3	-While using 60			
4	lifetime reserve days	All but	\$496 \$670	\$0
5		\$496 \$670 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 hospital			
19	for at least 3 days and			
20	entered a Medicare-			
21	approved facility within			
22	30 days after leaving the			
23	hospital			
24	First 20 days	All approved		
25		amounts	\$0	\$0
26	21st thru 100th day	All but	Up to	\$0
27		\$124 \$167.50	\$124 \$167.50	
28		a day	a day	
29	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		All but very		\$0
6		limited	Medicare	
7		copayment/	copayment/	
8		coinsurance	coinsurance	
9	You must meet	for outpatient		
10	Medicare's requirements,	drugs and		
11	including a doctor's	inpatient		
12	certification of	respite care		
13	terminal illness			

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

21 PLAN C

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

23 *Once you have been billed ~~\$131~~ **\$183** of Medicare-Approved
24 amounts for covered services (which are noted with an asterisk),
25 your Part B Deductible will have been met for the calendar year.

1	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
2	MEDICAL EXPENSES—			
3	In or out of the hospital			
4	and outpatient hospital			
5	treatment, such as			
6	Physician's services,			
7	inpatient and outpatient			
8	medical and surgical			
9	services and supplies,			
10	physical and speech			
11	therapy, diagnostic			
12	tests, durable medical			
13	equipment,			
14	First \$131 \$183 of			
15	Medicare Approved	\$0	\$131 \$183	\$0
16	Amounts*		(Part B	
17			Deductible)	
18	Remainder of Medicare			
19	Approved Amounts	80%	20%	\$0
20	Part B Excess Charges			
21	(Above Medicare			
22	Approved Amounts)	\$0	\$0	All Costs
23	BLOOD			
24	First 3 pints	\$0	All Costs	\$0
25	Next \$131 \$183 of Medicare			
26	Approved Amounts*	\$0	\$131 \$183	\$0
27			(Part B	
28			Deductible)	
29	Remainder of Medicare			

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

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 \$131 \$183 of			
16	Medicare Approved	\$0	\$131 \$183	\$0
17	Amounts*		(Part B	
18			Deductible)	
19	Remainder of Medicare			
20	Approved Amounts	80%	20%	\$0

21

OTHER BENEFITS—NOT COVERED BY MEDICARE

22	FOREIGN TRAVEL—			
----	-----------------	--	--	--

1	Not 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	\$50,000
13			of \$50,000	lifetime
14				maximum

15

PLAN D

16

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

17

*A benefit period begins on the first day you receive

18

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

19

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

20

any other facility for 60 days in a row.

21

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

1	services and supplies			
2	First 60 days	All but	\$992 \$1,340	\$0
3		\$992 \$1,340	(Part A	
4			Deductible)	
5	61st thru 90th day	All but	\$248 \$335	\$0
6		\$248 \$335 a day	a day	
7	91st day and after			
8	-While using 60			
9	lifetime reserve days	All but	\$496 \$670	\$0
10		\$496 \$670 a day	a day	
11	-Once lifetime reserve			
12	days are used:			
13	-Additional 365 days	\$0	100% of	\$0**
14			Medicare	
15			Eligible	
16			Expenses	
17	-Beyond the			
18	Additional 365 days	\$0	\$0	All Costs
19	SKILLED NURSING FACILITY			
20	CARE*			
21	You must meet Medicare's			
22	requirements, including			
23	having been in a hospital			
24	for at least 3 days and			
25	entered a Medicare-			
26	approved facility within			
27	30 days after leaving the			
28	hospital			
29	First 20 days	All approved		

1		amounts	\$0	\$0
2	21st thru 100th day	All but	Up to	\$0
3		\$124 \$167.50	\$124 \$167.50	
4		a day	A DAY	
5	101st day and after	\$0	\$0	All costs
6	BLOOD			
7	First 3 pints	\$0	3 pints	\$0
8	Additional amounts	100%	\$0	\$0
9	HOSPICE CARE			
10		All but very	Medicare	\$0
11		limited	copayment/	
12		copayment/	coinsurance	
13		coinsurance		
14	You must meet	for outpatient		
15	Medicare's requirements,	drugs and		
16	including a doctor's	inpatient		
17	certification of	respite care		
18	terminal illness			

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

26

PLAN D

27

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

1 *Once you have been billed ~~\$131~~ **\$183** of Medicare-Approved
2 amounts for covered services (which are noted with an asterisk),
3 your Part B Deductible will have been met for the calendar year.

4	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
5	MEDICAL EXPENSES—			
6	In or out of the hospital			
7	and outpatient hospital			
8	treatment, such as			
9	Physician's services,			
10	inpatient and outpatient			
11	medical and surgical			
12	services and supplies,			
13	physical and speech			
14	therapy, diagnostic			
15	tests, durable medical			
16	equipment,			
17	First \$131 \$183 of			
18	Medicare Approved	\$0	\$0	\$131 \$183
19	Amounts*			(Part B
20				Deductible)
21	Remainder of Medicare			
22	Approved Amounts	80%	20%	\$0
23	Part B Excess Charges			
24	(Above Medicare			
25	Approved Amounts)	\$0	\$0	All Costs
26	BLOOD			
27	First 3 pints	\$0	All Costs	\$0

1	Next \$131 \$183 of Medicare			
2	Approved Amounts*	\$0	\$0	\$131 \$183
3				(Part B
4				Deductible)
5	Remainder of Medicare			
6	Approved Amounts	80%	20%	\$0
7	CLINICAL LABORATORY			
8	SERVICES—			
9	Tests for			
10	diagnostic services	100%	\$0	\$0

11 PARTS A & B

12	HOME HEALTH CARE			
13	Medicare Approved			
14	Services			
15	—Medically necessary			
16	skilled care services			
17	and medical supplies	100%	\$0	\$0
18	—Durable medical			
19	equipment			
20	First \$131 \$183 of			
21	Medicare Approved	\$0	\$0	\$131 \$183
22	Amounts*			(Part B
23				Deductible)
24	Remainder of Medicare			
25	Approved Amounts	80%	20%	\$0

1 OTHER BENEFITS—NOT COVERED BY MEDICARE

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

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

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

23 **This ~~high deductible~~ **HIGH-DEDUCTIBLE** plan pays the same
 24 benefits as plan F after you have paid a calendar year ~~(\$1,860)~~

1 **\$2,240** deductible. Benefits from the ~~high deductible~~ **HIGH-**
 2 **DEDUCTIBLE** plan F will not begin until out-of-pocket expenses are
 3 ~~\$1,860.~~ **\$2,240**. Out-of-pocket expenses for this deductible are
 4 expenses that would ordinarily be paid by the policy. This
 5 includes ~~medicare~~ **MEDICARE** deductibles for part A and part B, but
 6 does not include the plan's separate foreign travel emergency
 7 deductible.

8	SERVICES	MEDICARE	AFTER YOU	IN ADDITION
9		PAYS	PAY	TO
10			\$1,860 \$2,240	\$1,860 \$2,240
11			DEDUCTIBLE**,	DEDUCTIBLE**,
12			PLAN PAYS	YOU PAY
13	HOSPITALIZATION*			
14	Semiprivate room and			
15	board, general nursing			
16	and miscellaneous			
17	services and supplies			
18	First 60 days	All but	\$992 \$1,340	\$0
19		\$992 \$1,340	(Part A	
20			Deductible)	
21	61st thru 90th day	All but	\$248 \$335	\$0
22		\$248 \$335	a day	
23		a day		
24	91st day and after			
25	-While using 60			
26	lifetime reserve days	All but	\$496 \$670	\$0
27		\$496 \$670	a day	
28		a day		

1	—Once lifetime reserve			
2	days are used:			
3	—Additional 365 days	\$0	100% of	\$0***
4			Medicare	
5			Eligible	
6			Expenses	
7	—Beyond the			
8	Additional 365 days	\$0	\$0	All Costs
9	SKILLED NURSING FACILITY			
10	CARE*			
11	You must meet Medicare's			
12	requirements, including			
13	having been in a			
14	hospital for at least			
15	3 days and entered a			
16	Medicare-approved			
17	facility within 30 days			
18	after leaving the			
19	hospital			
20	First 20 days	All approved		
21		amounts	\$0	\$0
22	21st thru 100th day	All but	Up to	\$0
23		\$124 \$167.50	\$124 \$167.50	
24		a day	a day	
25	101st day and after	\$0	\$0	All costs
26	BLOOD			
27	First 3 pints	\$0	3 pints	\$0
28	Additional amounts	100%	\$0	\$0
29	HOSPICE CARE			

1		All but very	Medicare	\$0
2		limited	copayment/	
3		copayment/	coinsurance	
4		coinsurance		
5	You must	for		
6	meet Medicare's	outpatient		
7	requirements, including	drugs and		
8	a doctor's certification	inpatient		
9	of terminal illness	respite care		

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

17 PLAN F

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

19 *Once you have been billed ~~\$131~~**\$183** of Medicare-Approved
20 amounts for covered services (which are noted with an asterisk),
21 your Part B Deductible will have been met for the calendar year.

22 **This ~~high deductible~~ **HIGH-DEDUCTIBLE** plan pays the same
23 benefits as plan F after you have paid a calendar year ~~(\$1,860)~~
24 **\$2,240** deductible. Benefits from the ~~high deductible~~ **HIGH-**
25 **DEDUCTIBLE** plan F will not begin until out-of-pocket expenses are
26 ~~\$1,860.~~ **\$2,240.** Out-of-pocket expenses for this deductible are

1 expenses that would ordinarily be paid by the policy. This
 2 includes ~~medicare~~ **MEDICARE** deductibles for part A and part B, but
 3 does not include the plan's separate foreign travel emergency
 4 deductible.

5	SERVICES	MEDICARE	AFTER YOU	IN ADDITION
6		PAYS	PAY	TO
7			\$1,860 \$2,240	\$1,860 \$2,240
8			DEDUCTIBLE**,	DEDUCTIBLE**,
9			PLAN PAYS	YOU PAY
10	MEDICAL EXPENSES—			
11	In or out of the hospital			
12	and outpatient hospital			
13	treatment, such as			
14	Physician's services,			
15	inpatient and outpatient			
16	medical and surgical			
17	services and supplies,			
18	physical and speech			
19	therapy, diagnostic			
20	tests, durable medical			
21	equipment,			
22	First \$131 \$183 of			
23	Medicare Approved	\$0	\$131 \$183	\$0
24	Amounts*		(Part B	
25			Deductible)	
26	Remainder of Medicare			
27	Approved Amounts	80%	20%	\$0
28	Part B Excess Charges			

1	(Above Medicare			
2	Approved Amounts)	\$0	100%	\$0
3	BLOOD			
4	First 3 pints	\$0	All Costs	\$0
5	Next \$131 \$183 of			
6	Medicare Approved	\$0	\$131 \$183	\$0
7	Amounts*		(Part B	
8			Deductible)	
9	Remainder of Medicare			
10	Approved Amounts	80%	20%	\$0
11	CLINICAL LABORATORY			
12	SERVICES—			
13	Tests for			
14	diagnostic services	100%	\$0	\$0

15

PARTS A & B

16	HOME HEALTH CARE			
17	Medicare Approved			
18	Services			
19	—Medically necessary			
20	skilled care services			
21	and medical supplies	100%	\$0	\$0
22	—Durable medical			
23	equipment			
24	First \$131 \$183 of			
25	Medicare Approved	\$0	\$131 \$183	\$0
26	Amounts*		(Part B	

1			Deductible)	
2	Remainder of Medicare			
3	Approved Amounts	80%	20%	\$0

4 OTHER BENEFITS—NOT COVERED BY MEDICARE

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

20 PLAN G OR HIGH-DEDUCTIBLE PLAN G

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

22 *A benefit period begins on the first day you receive
 23 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 **** THIS HIGH-DEDUCTIBLE PLAN PAYS THE SAME BENEFITS AS PLAN**
 4 **G AFTER ONE HAS PAID A CALENDAR YEAR \$2,240 DEDUCTIBLE. BENEFITS**
 5 **FROM THE HIGH-DEDUCTIBLE PLAN G WILL NOT BEGIN UNTIL OUT-OF-**
 6 **POCKET EXPENSES ARE \$2,240. OUT-OF-POCKET EXPENSES FOR THIS**
 7 **DEDUCTIBLE INCLUDE EXPENSES FOR THE MEDICARE PART B DEDUCTIBLE,**
 8 **AND EXPENSES THAT WOULD ORDINARILY BE PAID BY THE POLICY. THIS**
 9 **DOES NOT INCLUDE THE PLAN'S SEPARATE FOREIGN TRAVEL EMERGENCY**
 10 **DEDUCTIBLE.**

11			AFTER YOU	IN ADDITION
12			PAY \$2,240	TO \$2,240
13			DEDUCTIBLE,	DEDUCTIBLE,
14			**	**
15	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
16	HOSPITALIZATION*			
17	Semiprivate room and			
18	board, general nursing			
19	and miscellaneous			
20	services and supplies			
21	First 60 days	All but	\$992 \$1,340	\$0
22		\$992 \$1,340	(Part A	
23			Deductible)	
24	61st thru 90th day	All but	\$248 \$335	\$0
25		\$248 \$335 a day	a day	
26	91st day and after			

1	-While using 60			
2	lifetime reserve days	All but	\$496 \$670	\$0
3		\$496 \$670 a day	a day	
4	-Once lifetime reserve			
5	days are used:			
6	-Additional 365 days	\$0	100% of	\$0***
7			Medicare	
8			Eligible	
9			Expenses	
10	-Beyond the			
11	Additional 365 days	\$0	\$0	All Costs
12	SKILLED NURSING FACILITY			
13	CARE*			
14	You must meet Medicare's			
15	requirements, including			
16	having been in a hospital			
17	for at least 3 days and			
18	entered a Medicare-			
19	approved facility within			
20	30 days after leaving the			
21	hospital			
22	First 20 days	All approved		
23		amounts	\$0	\$0
24	21st thru 100th day	All but	Up to	\$0
25		\$124 \$167.50	\$124 \$167.50	
26		a day	a day	
27	101st day and after	\$0	\$0	All costs
28	BLOOD			
29	First 3 pints	\$0	3 pints	\$0

1	Additional amounts	100%	\$0	\$0
2	HOSPICE CARE			
3		All but very		\$0
4		limited	Medicare	
5		copayment/	copayment/	
6		coinsurance	coinsurance	
7	You must meet	for outpatient		
8	Medicare's requirements,	drugs and		
9	including a doctor's	inpatient		
10	certification of	respite care		
11	terminal illness			

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 G OR HIGH-DEDUCTIBLE PLAN G**

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

21 *Once you have been billed ~~\$131~~ **\$183** 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**
 25 **G AFTER ONE HAS PAID A CALENDAR YEAR \$2,240 DEDUCTIBLE. BENEFITS**
 26 **FROM THE HIGH-DEDUCTIBLE PLAN G WILL NOT BEGIN UNTIL OUT-OF-**

1 POCKET EXPENSES ARE \$2,240. OUT-OF-POCKET EXPENSES FOR THIS
 2 DEDUCTIBLE INCLUDE EXPENSES FOR THE MEDICARE PART B DEDUCTIBLE,
 3 AND EXPENSES THAT WOULD ORDINARILY BE PAID BY THE POLICY. THIS
 4 DOES NOT INCLUDE THE PLAN'S SEPARATE FOREIGN TRAVEL EMERGENCY
 5 DEDUCTIBLE.

6			IN
7		AFTER YOU	ADDITION TO
8		PAY \$2,240	PAY \$2,240
9		DEDUCTIBLE,	DEDUCTIBLE,
10		**	**
11	SERVICES	MEDICARE PAYS	PLAN PAYS
12	MEDICAL EXPENSES—		YOU PAY
13	In or out of the hospital		
14	and outpatient hospital		
15	treatment, such as		
16	Physician's services,		
17	inpatient and outpatient		
18	medical and surgical		
19	services and supplies,		
20	physical and speech		
21	therapy, diagnostic		
22	tests, durable medical		
23	equipment,		
24	First \$131 \$183 of		
25	Medicare Approved	\$0	\$131 \$163

1	Amounts*			(UNLESS
2				Part B
3				Deductible
4				HAS BEEN
5				MET)
6	Remainder of Medicare			
7	Approved Amounts	80%	20%	\$0
8	Part B Excess Charges			
9	(Above Medicare			
10	Approved Amounts)	\$0	100%	0%
11	BLOOD			
12	First 3 pints	\$0	All Costs	\$0
13	Next \$131 \$183 of			
14	Medicare Approved	\$0	\$0	\$131 \$183
15	Amounts*			(UNLESS
16				Part B
17				Deductible
18				HAS BEEN
19				MET)
20	Remainder of Medicare			
21	Approved Amounts	80%	20%	\$0
22	CLINICAL LABORATORY			
23	SERVICES--			
24	Tests for			
25	diagnostic services	100%	\$0	\$0

26

PARTS A & B

1	HOME HEALTH CARE			
2	Medicare Approved			
3	Services			
4	—Medically necessary			
5	skilled care services			
6	and medical supplies	100%	\$0	\$0
7	—Durable medical			
8	equipment			
9	First \$131 \$183 of			
10	Medicare Approved	\$0	\$0	\$131 \$183
11	Amounts*			(UNLESS
12				Part B
13				Deductible
14				HAS BEEN
15				MET)
16	Remainder of Medicare			
17	Approved Amounts	80%	20%	\$0

18 OTHER BENEFITS—NOT COVERED BY MEDICARE

19	FOREIGN TRAVEL—			
20	Not covered by Medicare			
21	Medically necessary			
22	emergency care services			
23	beginning during the			
24	first 60 days of each			
25	trip outside the USA			
26	First \$250 each			

1	calendar year	\$0	\$0	\$250
2	Remainder of charges	\$0	80% to a	20% and
3			lifetime	amounts
4			maximum	over the
5			benefit	\$50,000
6			of \$50,000	lifetime
7				maximum

8 PLAN K

9 *You will pay half the cost-sharing of some covered services
10 until you reach the annual out-of-pocket limit of ~~\$4,140~~ **\$5,240**
11 each calendar year. The amounts that count toward your annual
12 limit are noted with diamonds¹ in the chart below. Once you reach
13 the annual limit, the plan pays 100% of your Medicare copayment
14 and coinsurance for the rest of the calendar year. However, this
15 limit does NOT include charges from your provider that exceed
16 Medicare-approved amounts (these are called "Excess Charges") and
17 you will be responsible for paying this difference in the amount
18 charged by your provider and the amount paid by Medicare for the
19 item or service.

20 PLAN K

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

22 **A benefit period begins on the first day you receive
23 service as an inpatient in a hospital and ends after you have
24 been out of the hospital and have not received skilled care in

1 any other facility for 60 days in a row.

2	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
3	HOSPITALIZATION**			
4	Semiprivate room and			
5	board, general nursing			
6	and miscellaneous			
7	services and supplies			
8	First 60 days	All but	\$496 \$670	\$496 \$670
9		\$992 \$1,340	(50%	(50% of
10			of Part A	Part A
11			Deducti-	Deductible) 1
12			ble)	
13				
14	61st thru 90th day	All but	\$248 \$335	\$0
15		\$248 \$335 a day	a day	
16	91st day and after:			
17	-While using 60			
18	lifetime reserve days	All but	\$496 \$670	\$0
19		\$496 \$670 a day	a day	
20	-Once lifetime reserve			
21	days are used:			
22	-Additional 365 days	\$0	100% of	\$0***
23			Medicare	
24			Eligible	
25			Expenses	
26	-Beyond the			
27	Additional 365 days	\$0	\$0	All Costs
28	SKILLED NURSING FACILITY			

1	CARE**			
2	You must meet Medicare's			
3	requirements, including			
4	having been in a hospital			
5	for at least 3 days and			
6	entered a Medicare-			
7	approved facility within			
8	30 days after leaving the			
9	hospital			
10	First 20 days	All approved		
11		amounts	\$0	\$0
12	21st thru 100th day	All but	Up to	Up to
13		\$124 \$167.50	\$62 \$83.75	\$62 \$83.75
14		a day	a day	a day 1
15	101st day and after	\$0	\$0	All costs
16	BLOOD			
17	First 3 pints	\$0	50%	50% 1
18	Additional amounts	100%	\$0	\$0
19	HOSPICE CARE			
20			50% of	50% of
21			copayment/	Medicare
22			coinsur-	copayment/
23			ance	coinsurance 1
24	You must meet			
25	Medicare's requirements,			
26	including a doctor's			
27	certification of terminal			
28	illness	All but very		
29		limited		

1	copayment/		
2	coinsurance for		
3	outpatient		
4	drugs and		
5	inpatient		
6	respite care		

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

14 PLAN K

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

16 ****Once you have been billed ~~\$131~~ **\$183** of Medicare-Approved
17 amounts for covered services (which are noted with an asterisk),
18 your Part B Deductible will have been met for the calendar year.

19	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
20	MEDICAL EXPENSES—			
21	In or out of the hospital			
22	and outpatient hospital			
23	treatment, such as			
24	Physician's services,			

1	inpatient and outpatient			
2	medical and surgical			
3	services and supplies,			
4	physical and speech			
5	therapy, diagnostic			
6	tests, durable medical			
7	equipment,			
8	First \$131 \$183 of			
9	Medicare Approved	\$0	\$0	\$131 \$183
10	Amounts****			(Part B
11				Deductible)
12				**** 1
13				
14	Preventive Benefits for	Generally 75%	Remainder	All costs
15	Medicare covered	or more of	of Medi-	above Medi-
16	services	Medicare ap-	care	care
17		proved amounts	approved	approved
18			amounts	amounts
19	Remainder of Medicare	Generally 80%	Generally	Generally
20	Approved Amounts		10%	10% 1
21				
22	Part B Excess Charges	\$0	\$0	All costs
23	(Above Medicare			(and they do
24	Approved Amounts)			not count
25				toward
26				annual out-
27				of-pocket
28				limit of
29				\$4,140)*

1				\$5,240) *
2	BLOOD			
3	First 3 pints	\$0	50%	50% 1
4	Next \$131 —\$183 of			
5	Medicare Approved	\$0	\$0	\$131 —\$183
6	Amounts****			(Part B
7				Deductible)
8				**** 1
9	Remainder of Medicare	Generally 80%	Generally	Generally
10	Approved Amounts		10%	10% 1
11	CLINICAL LABORATORY			
12	SERVICES—Tests for			
13	diagnostic services	100%	\$0	\$0

14 *This plan limits your annual out-of-pocket payments for
15 Medicare-approved amounts to ~~\$4,140~~ **\$5,240** per year. However,
16 this limit does NOT include charges from your provider that
17 exceed Medicare-approved amounts (these are called "Excess
18 Charges") and you will be responsible for paying this difference
19 in the amount charged by your provider and the amount paid by
20 Medicare for the item or service.

21 PARTS A & B

22	HOME HEALTH CARE			
23	Medicare Approved			
24	Services			
25	—Medically necessary			

1	skilled care services			
2	and medical supplies	100%	\$0	\$0
3	Durable medical			
4	equipment			
5	First \$131 \$183 of			
6	Medicare Approved	\$0	\$0	\$131 \$183
7	Amounts*****			(Part B
8				Deductible) 1
9	Remainder of Medicare			
10	Approved Amounts	80%	10%	10% 1

11 *****Medicare benefits are subject to change. Please consult
 12 the latest Guide to Health Insurance for People with Medicare.

13 PLAN L

14 *You will pay one-fourth of the cost-sharing of some covered
 15 services until you reach the annual out-of-pocket limit of ~~\$2,070~~
 16 **\$2,620** each calendar year. The amounts that count toward your
 17 annual limit are noted with diamonds¹ in the chart below. Once you
 18 reach the annual limit, the plan pays 100% of your Medicare
 19 copayment and coinsurance for the rest of the calendar year.
 20 However, this limit does NOT include charges from your provider
 21 that exceed Medicare-approved amounts (these are called "Excess
 22 Charges") and you will be responsible for paying this difference
 23 in the amount charged by your provider and the amount paid by
 24 Medicare for the item or service.

25 PLAN L

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	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
7	HOSPITALIZATION**			
8	Semiprivate room and			
9	board, general nursing			
10	and miscellaneous			
11	services and supplies			
12	First 60 days	All but	\$744 \$1,005	\$248 \$335
13		\$992 \$1,340	(75% of	(25% of
14			Part A	Part A
15			Deducti-	Deductible) 1
16			ble)	
17	61st thru 90th day	All but	\$248 \$335	\$0
18		\$248 \$335 a day	a day	
19	91st day and after:			
20	-While using 60			
21	lifetime reserve days	All but	\$496 \$670	\$0
22		\$496 \$670 a day	a day	
23	-Once lifetime reserve			
24	days are used:			
25	-Additional 365 days	\$0	100% of	\$0***
26			Medicare	
27			Eligible	

1			Expenses	
2	-Beyond the			
3	Additional 365 days	\$0	\$0	All Costs
4	SKILLED NURSING FACILITY			
5	CARE**			
6	You must meet Medicare's			
7	requirements, including			
8	having been in a hospital			
9	for at least 3 days and			
10	entered a Medicare-			
11	approved facility within			
12	30 days after leaving the			
13	hospital			
14	First 20 days	All approved		
15		amounts	\$0	\$0
16	21st thru 100th day	All but	Up to	Up to
17		\$124 \$167.50 a	\$93 \$125.63	\$31 \$41.88
18		day	a day	a day 1
19	101st day and after	\$0	\$0	All costs
20	BLOOD			
21	First 3 pints	\$0	75%	25% 1
22	Additional amounts	100%	\$0	\$0
23	HOSPICE CARE			
24			75% of	25% of
25			copayment/	copayment/
26			coinsur-	coinsurance 1
27			ance	
28	You must meet			
29	Medicare's requirements,			

1	including a doctor's		
2	certification of terminal	All	
3	illness	but very	
4		limited copay-	
5		ment/coinsur-	
6		ance for	
7		outpatient	
8		drugs and	
9		inpatient	
10		respite care	

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

18 PLAN L

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

20 ****Once you have been billed ~~\$131~~**\$183** of Medicare-Approved
21 amounts for covered services (which are noted with an asterisk),
22 your Part B Deductible will have been met for the calendar year.

23	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
24	MEDICAL EXPENSES—			

1	In or out of the hospital			
2	and outpatient hospital			
3	treatment, such as			
4	Physician's services,			
5	inpatient and outpatient			
6	medical and surgical			
7	services and supplies,			
8	physical and speech			
9	therapy, diagnostic			
10	tests, durable medical			
11	equipment,			
12	First \$131 \$183 of			
13	Medicare Approved	\$0	\$0	\$131 \$183
14	Amounts****			(Part
15				B Deducti-
16				ble)**** 1
17	Preventive Benefits for	Generally 75%	Remainder	All costs
18	Medicare covered	or more of	of Medi-	above Medi-
19	services	Medicare	care	care
20		approved	approved	approved
21		amounts	amounts	amounts
22	Remainder of Medicare	Generally	Generally	Generally
23	Approved Amounts	80%	15%	5% 1
24				
25	Part B Excess Charges	\$0	\$0	All costs
26	(Above Medicare			(and they do
27	Approved Amounts)			not count
28				toward
29				annual out-

1				of-pocket
2				limit of
3				\$2,070) *
4				\$2,620) *
5	BLOOD			
6	First 3 pints	\$0	75%	25% 1
7	Next \$131 \$183 of			
8	Medicare Approved	\$0	\$0	\$131 \$183
9	Amounts****			(Part B
10				Deductible) 1
11	Remainder of Medicare	Generally	Generally	Generally
12	Approved Amounts	80%	15%	5% 1
13	CLINICAL LABORATORY			
14	SERVICES—Tests for			
15	diagnostic services	100%	\$0	\$0

16 *This plan limits your annual out-of-pocket payments for
17 Medicare-approved amounts to ~~\$2,070~~ **\$2,620** per year. However,
18 this limit does NOT include charges from your provider that
19 exceed Medicare-approved amounts (these are called "Excess
20 Charges") and you will be responsible for paying this difference
21 in the amount charged by your provider and the amount paid by
22 Medicare for the item or service.

23 PARTS A & B

24	HOME HEALTH CARE			
25	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 \$183 of			
8	Medicare Approved	\$0	\$0	\$131 \$183
9	Amounts*****			(Part
10				B Deducti-
11				ble) 1
12	Remainder of Medicare			
13	Approved Amounts	80%	15%	5% 1

14 *****Medicare benefits are subject to change. Please consult
 15 the latest Guide to Health Insurance for People with Medicare.

16 PLAN M
 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 \$992	\$496 \$670	\$496 \$670
4		\$1,340	(50%	(50%
5			of Part A	of Part A
6			Deduc-	Deduc-
7			tible)	tible)
8	61st thru 90th day	All but \$248	\$248 \$335	\$0
9		\$335 a day	a day	
10	91st day and after:			
11	-While using 60			
12	lifetime reserve days	All but \$496	\$496 \$670	\$0
13		\$670 a day	a day	
14	-Once lifetime reserve			
15	days are used:			
16	-Additional 365 days	\$0	100% of	\$0**
17			Medicare	
18			Eligible	
19			Expenses	
20	-Beyond the			
21	Additional 365 days	\$0	\$0	All Costs
22	SKILLED NURSING FACILITY			
23	CARE*			
24	You must meet Medicare's			
25	requirements, including			
26	having been in a hospital			
27	for at least 3 days and			
28	entered a Medicare-			
29	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		\$167.50 a day	\$167.50	
7			a day	
8	101st day and after	\$0	\$0	All costs
9	BLOOD			
10	First 3 pints	\$0	3 pints	\$0
11	Additional amounts	100%	\$0	\$0
12	HOSPICE CARE			
13	You must meet Medicare's	All but very	Medicare	\$0
14	requirements, including	limited	copayment/	
15	a doctor's	copayment/	coinsurance	
16	certification of	coinsurance		
17	terminal illness	for outpatient		
18		drugs and		
19		inpatient		
20		respite care		

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

1

PLAN M

2

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

3

*Once you have been billed ~~\$131~~**\$183** of Medicare-approved

4

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

5

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

6	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
7	MEDICAL EXPENSES—			
8	In or out of the			
9	hospital and outpatient			
10	hospital treatment, such			
11	as Physician's services,			
12	inpatient and outpatient			
13	medical and surgical			
14	services and supplies,			
15	physical and speech			
16	therapy, diagnostic			
17	tests, durable medical			
18	equipment			
19	First \$131 \$183			
20	of Medicare	\$0	\$0	\$131 \$183
21	Approved Amounts*			(Part B
22				Deduc-
23				tible)
24	Remainder of Medicare			
25	Approved Amounts	Generally	Generally	\$0
26		80%	20%	
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 \$131 \$183			
6	of Medicare	\$0	\$0	\$131 \$183
7	Approved Amounts*			(Part B
8				Deduc-
9				tible)
10	Remainder of Medicare			
11	Approved Amounts	80%	20%	\$0
12	CLINICAL LABORATORY			
13	SERVICES—Tests for			
14	diagnostic services	100%	\$0	\$0

15 PARTS A & B

16	HOME HEALTH CARE			
17	Medicare Approved			
18	Services			
19	—Medically necessary			
20	skilled care services			
21	and medical supplies	100%	\$0	\$0
22	—Durable medical			
23	equipment			
24	First \$131 \$183 of			
25	Medicare Approved			
26	Amounts	\$0	\$0	\$131 \$183

1				(Part B
2				Deduc-
3				tible)
4	Remainder of Medicare			
5	Approved Amounts	80%	20%	\$0

6 OTHER BENEFITS—NOT COVERED BY MEDICARE

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

22 PLAN N

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

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

1 service as an inpatient in a hospital and ends after you have
 2 been out of the hospital and have not received skilled care in
 3 any other facility for 60 days in a row.

4	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
5	HOSPITALIZATION*			
6	Semiprivate room and			
7	board, general nursing			
8	and miscellaneous			
9	services and supplies			
10	First 60 days	All but \$992	\$992 \$1,340	\$0
11		\$1,340	(Part A	
12			Deduc-	
13			tible)	
14	61st thru 90th day	All but \$248	\$248 \$335	\$0
15		\$335 a day	a day	
16	91st day and after:			
17	-While using 60			
18	lifetime reserve days	All but \$496	\$496 \$670	\$0
19		\$670 a day	a day	
20	-Once lifetime reserve			
21	days are used:			
22	-Additional 365 days	\$0	100% of	\$0**
23			Medicare	
24			Eligible	
25			Expenses	
26	-Beyond the			
27	Additional 365 days	\$0	\$0	All Costs

1	SKILLED NURSING FACILITY			
2	CARE*			
3	You must meet Medicare's			
4	requirements, including			
5	having been in a hospital			
6	for at least 3 days and			
7	entered a Medicare-			
8	approved facility within			
9	30 days after leaving the			
10	hospital			
11	First 20 days	All approved	\$0	\$0
12		amounts		
13	21st thru 100th day	All but \$124	Up to \$124	\$0
14		\$167.50 a day	\$167.50 a	
15			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	You must meet Medicare's	All but very	Medicare	\$0
22	requirements, including	limited	copayment/	
23	a doctor's certification	copayment/	coinsurance	
24	of terminal illness	coinsurance		
25		for outpatient		
26		drugs and		
27		inpatient		
28		respite care		

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

8

PLAN N

9

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

10 *Once you have been billed ~~\$131~~**\$183** of Medicare-approved
 11 amounts for covered services (which are noted with an asterisk),
 12 your Part B deductible will have been met for the calendar year.

13	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
14	MEDICAL EXPENSES—			
15	IN OR OUT OF THE			
16	HOSPITAL AND OUTPATIENT			
17	HOSPITAL TREATMENT, such			
18	as physician's services,			
19	inpatient and outpatient			
20	medical and surgical			
21	services and supplies,			
22	physical and speech			
23	therapy, diagnostic			
24	tests, durable medical			
25	equipment			
26	First \$131 \$183			

1	of Medicare	\$0	\$0	\$131 \$183
2	Approved Amounts*			(Part B
3				Deduc-
4				tible)
5	Remainder of Medicare			
6	Approved Amounts	Generally	Balance,	Up to \$20
7		80%	other than	per office
8			up to \$20	visit and
9			per office	up to \$50
10			visit and	per
11			up to \$50	emergency
12			per	room
13			emergency	visit. The
14			room visit.	copayment
15			The	of up to
16			copayment	\$50 is
17			of up to	waived if
18			\$50 is	the
19			waived if	insured is
20			the insured	admitted
21			is admitted	to any
22			to any	hospital
23			hospital	and the
24			and the	emergency
25			emergency	visit is
26			visit is	covered as
27			covered as	a Medicare
28			a Medicare	Part A
29			Part A	expense.

1			expense.	
2	Part B Excess Charges			
3	(Above Medicare			
4	Approved Amounts)	\$0	\$0	All costs
5	BLOOD			
6	First 3 pints	\$0	All costs	\$0
7	Next \$131 \$183			
8	of Medicare	\$0	\$0	\$131 \$183
9	Approved Amounts*			(Part B
10				Deduc-
11				tible)
12	Remainder of Medicare			
13	Approved Amounts	80%	20%	\$0
14	CLINICAL LABORATORY			
15	SERVICES—Tests for			
16	diagnostic services	100%	\$0	\$0

17 PARTS A & B

18	HOME HEALTH CARE			
19	Medicare Approved			
20	Services			
21	—Medically necessary			
22	skilled care services			
23	and medical supplies	100%	\$0	\$0
24	—Durable medical			
25	equipment			
26	First \$131 \$183 of			

1	Medicare Approved			
2	Amounts*	\$0	\$0	\$131 \$183
3				(Part B
4				Deduc-
5				tible)
6	Remainder of Medicare			
7	Approved Amounts	80%	20%	\$0

8 OTHER BENEFITS—NOT COVERED BY MEDICARE

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

24 Sec. 3819a. (1) This section applies to all ~~medicare~~
 25 **MEDICARE** supplement policies or certificates delivered or issued

1 for delivery with an effective date for coverage on or after June
2 1, 2010.

3 (2) An insurance policy ~~shall~~**MUST** not be titled,
4 advertised, solicited, or issued for delivery in this state as a
5 ~~medicare~~**MEDICARE** supplement policy if the policy does not meet
6 the minimum standards prescribed in this section. These minimum
7 standards are in addition to all other requirements of this
8 chapter. An issuer shall not offer any 1990 plan for sale on or
9 after June 1, 2010. Benefit standards applicable to ~~medicare~~
10 **MEDICARE** supplement policies and certificates issued before June
11 1, 2010 remain subject to the requirements of section 3819.

12 (3) The following standards apply to ~~medicare~~**MEDICARE**
13 supplement policies:

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

22 (b) A ~~medicare~~**MEDICARE** supplement policy ~~shall~~**MUST** not
23 indemnify against losses resulting from sickness on a different
24 basis than losses resulting from accidents.

25 (c) A ~~medicare~~**MEDICARE** supplement policy ~~shall~~**MUST** provide
26 that benefits designed to cover cost-sharing amounts under
27 ~~medicare~~**MEDICARE** will be changed automatically to coincide with

1 any changes in the applicable ~~medicare~~**MEDICARE** deductible,
 2 copayment, or coinsurance amounts. Premiums may be modified to
 3 correspond with such changes.

4 (d) A ~~medicare~~**MEDICARE** supplement policy ~~shall~~**MUST** be
 5 guaranteed renewable. Termination ~~shall~~**MUST** be for nonpayment of
 6 premium or material misrepresentation only.

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

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

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

1 the date the individual becomes entitled to the assistance. ~~Upon~~
 2 **ON** receipt of timely notice, the insurer shall return to the
 3 policyholder or certificate holder that portion of the premium
 4 attributable to the period of ~~medicaid~~ **MEDICAID** eligibility,
 5 subject to adjustment for paid claims. If a suspension occurs and
 6 if the policyholder or certificate holder loses entitlement to
 7 medical assistance under ~~medicaid~~, **MEDICAID**, the policy ~~shall~~
 8 **MUST** be automatically reinstituted effective as of the date of
 9 termination of the assistance if the policyholder or certificate
 10 holder provides notice of loss of ~~medicaid~~ **MEDICAID** medical
 11 assistance within 90 days after the date of the loss and pays the
 12 premium attributable to the period effective as of the date of
 13 termination of the assistance. ~~Each medicare~~ **A MEDICARE**
 14 supplement policy ~~shall~~ **MUST** provide that benefits and premiums
 15 under the policy ~~shall~~ **WILL** be suspended at the request of the
 16 policyholder if the policyholder is entitled to benefits under
 17 ~~section 226(b) of title II of the social security act~~ **42 USC**
 18 **426(B)**, and is covered under a group health plan as defined in
 19 ~~section 1862(b) (1) (A) (v) of the social security act.~~ **42 USC**
 20 **1395Y (B) (1) (A) (v)**. If suspension occurs and if the policyholder
 21 or certificate holder loses coverage under the group health plan,
 22 the policy ~~shall~~ **MUST** be automatically reinstituted effective as
 23 of the date of loss of coverage if the policyholder provides
 24 notice of loss of coverage within 90 days after the date of the
 25 loss and pays the premium attributable to the period, effective
 26 as of the date of termination of enrollment in the group health
 27 plan. All of the following apply to the reinstitution of a

1 ~~medicare~~**MEDICARE** supplement policy under this subsection:

2 (a) The reinstatement ~~shall~~**MUST** not provide for any waiting
3 period with respect to treatment of preexisting conditions.

4 (b) Reinstated coverage ~~shall~~**MUST** be substantially
5 equivalent to coverage in effect before the date of the
6 suspension.

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

12 Sec. 3827. (1) A ~~medicare~~**MEDICARE** supplement insurance
13 policy or certificate ~~shall~~**MUST** not be delivered or issued for
14 delivery in this state if the policy or certificate provides
15 benefits that duplicate benefits provided by ~~medicare~~**MEDICARE**.

16 (2) Application forms or a supplementary application or
17 other form to be signed by the applicant and agent for ~~medicare~~
18 **MEDICARE** supplement policies, ~~shall~~**WHICH MAY BE PROVIDED IN**
19 **WRITTEN OR ELECTRONIC FORMAT, MUST** include the following
20 statements and questions designed to inform and elicit
21 information as to whether, ~~as of~~**ON** the date of the application,
22 the applicant ~~currently has~~ ~~medicare~~**MEDICARE** supplement,
23 ~~medicare~~**MEDICARE** advantage, ~~medicaid~~**MEDICAID** coverage, or
24 another health insurance policy or certificate in force or
25 whether a ~~medicare~~**MEDICARE** supplement policy or certificate is
26 intended to replace any ~~disability or other~~ health policy or
27 certificate presently in force:

[STATEMENTS]

(1) You do not need more than 1 ~~medicare~~**MEDICARE** supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) If you are 65 or older, you may be eligible for benefits under ~~medicaid~~**MEDICAID** and may not need a ~~medicare~~**MEDICARE** supplement policy.

(4) If, after purchasing this policy, you become eligible for ~~medicaid~~**MEDICAID**, the benefits and premiums under your ~~medicare~~**MEDICARE** supplement policy will be suspended during your entitlement to benefits under ~~medicaid~~**MEDICAID** for 24 months. You must request this suspension within 90 days ~~of~~**AFTER** becoming eligible for ~~medicaid~~**MEDICAID**. If you are no longer entitled to ~~medicaid~~**MEDICAID**, your suspended ~~medicare~~**MEDICARE** supplement policy, or, if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days ~~of~~**AFTER** losing ~~medicaid~~**MEDICAID** eligibility. If the ~~medicare~~**MEDICARE** supplement provided coverage for outpatient prescription drugs and you enrolled in ~~medicare~~**MEDICARE** part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in, a ~~medicare~~**MEDICARE** supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your ~~medicare~~**MEDICARE** supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your ~~medicare~~**MEDICARE** supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended ~~medicare~~**MEDICARE** supplement policy, or if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days ~~of~~**AFTER** losing your employer or union-based group health plan. If the ~~medicare~~**MEDICARE** supplement policy provided coverage for outpatient prescription drugs and you enrolled in ~~medicare~~**MEDICARE** part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of ~~medicare~~**MEDICARE** supplement insurance and concerning ~~medicaid~~**MEDICAID**.

[QUESTIONS]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a ~~medicare~~**MEDICARE** supplement insurance policy, or that you had certain rights to buy such a

policy, you may be guaranteed acceptance in one or more of our
~~medicare~~**MEDICARE** supplement plans. Please include a copy of the
 notice from your prior insurer with your application. PLEASE
 ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X"]

To the best of your knowledge,

(1) (a) Did you turn age 65 in the last 6 months?

Yes ____ No ____

(b) Did you enroll in ~~medicare~~**MEDICARE** part B in the
 last 6 months?

Yes ____ No ____

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the
 state ~~medicaid~~**MEDICAID** program?

[NOTE TO APPLICANT: If you are participating in a
 "Spend-Down Program" and have not met your "Share
 of Cost," please answer NO to this question.]

Yes ____ No ____

If yes,

(a) Will ~~medicaid~~**MEDICAID** pay your premiums for this
~~medicare~~**MEDICARE** supplement policy?

Yes ____ No ____

(b) Do you receive any benefits from ~~medicaid~~**MEDICAID**
 OTHER THAN payments toward your ~~medicare~~**MEDICARE**
 part B premium?

Yes ____ No ____

(3) (a) If you had coverage from any ~~medicare~~**MEDICARE** plan
 other than original ~~medicare~~**MEDICARE** within the

past 63 days (for example, a ~~medicare~~**MEDICARE** advantage plan, or a ~~medicare~~**MEDICARE** HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START ___/___/___ END ___/___/___

(b) If you are still covered under the ~~medicare~~**MEDICARE** plan, do you intend to replace your current coverage with this new ~~medicare~~**MEDICARE** supplement policy?

Yes ____ No ____

(c) Was this your first time in this type of ~~medicare~~**MEDICARE** plan?

Yes ____ No ____

(d) Did you drop a ~~medicare~~**MEDICARE** supplement policy to enroll in the ~~medicare~~**MEDICARE** plan?

Yes ____ No ____

(4) (a) Do you have another ~~medicare~~**MEDICARE** supplement policy in force?

Yes ____ No ____

(b) If so, with what company, and what plan do you have [optional for direct mailers]?

(c) If so, do you intend to replace your current ~~medicare~~**MEDICARE** supplement policy with this policy?

Yes ____ No ____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes ____ No ____

(a) If so, with what company and what kind of policy?

(b) What are your dates of coverage under the other policy?

START __/__/__ END __/__/__

(If you are still covered under the other policy,
leave "END" blank.)

(3) An agent shall list on the application form for a ~~medicare~~**MEDICARE** supplement policy any other health insurance policies, certificates, or contracts he or she has sold to the applicant, including policies, certificates, or contracts sold that are still in force and policies, certificates, and contracts sold in the past 5 years that are no longer in force.

(4) For a direct response insurer, **THE INSURER SHALL RETURN** a copy of the application or supplement form, signed by the applicant, and acknowledged by the insurer, ~~shall be returned to~~ the applicant ~~by the insurer upon~~ **ON** delivery of the policy or certificate.

(5) ~~Upon~~**ON** determining that a sale will involve replacement of ~~medicare~~**MEDICARE** supplement coverage, an insurer, other than a direct response insurer or its agent, shall furnish the applicant ~~prior to~~**BEFORE** issuance or delivery of the ~~medicare~~**MEDICARE** supplement policy the following notice regarding

1 replacement of ~~medicare~~**MEDICARE** supplement coverage. One copy of
 2 the notice signed by the applicant and the agent, ~~except where~~
 3 **UNLESS THE** coverage is sold without an agent, ~~shall~~**MUST** be
 4 provided to the applicant and an additional signed copy ~~shall~~
 5 **MUST** be retained by the insurer. A direct response insurer shall
 6 deliver to the applicant at the time of issuance of the policy or
 7 certificate the following notice, regarding replacement of
 8 ~~medicare~~**MEDICARE** supplement coverage. The notice regarding
 9 replacement of ~~medicare~~**MEDICARE** supplement coverage ~~shall~~**MUST**
 10 be provided in substantially the following form and in not less
 11 than 12-point type:

12 "NOTICE TO APPLICANT REGARDING REPLACEMENT
 13 OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE ADVANTAGE
 14 (INSURANCE COMPANY'S NAME AND ADDRESS)
 15 SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

16 According to (your application) (information you have
 17 furnished), you intend to drop or otherwise terminate existing
 18 ~~medicare~~**MEDICARE** supplement coverage or ~~medicare~~**MEDICARE**
 19 advantage plan and replace it with a policy or certificate to be
 20 issued by (company name) insurance company. Your new policy or
 21 certificate provides 30 days within which you may decide without
 22 cost whether you desire to keep the policy or certificate.

23 You should review this new coverage carefully comparing it
 24 with all disability and other health coverage you now have and
 25 terminate your present coverage only if, after due consideration,
 26 you find that purchase of this ~~medicare~~**MEDICARE** supplement

1 coverage is a wise decision.

2 Statement to applicant by insurer, agent, or other
3 representative:

4 (Use additional sheets as necessary.)

5 I have reviewed your current medical or health coverage. The
6 replacement of coverage involved in this transaction does not
7 duplicate your existing ~~medicare~~**MEDICARE** supplement, or, if
8 applicable, ~~medicare~~**MEDICARE** advantage coverage because you
9 intend to terminate your existing ~~medicare~~**MEDICARE** supplement
10 coverage or leave your ~~medicare~~**MEDICARE** advantage plan, to the
11 best of my knowledge. The replacement policy is being purchased
12 for the following reasons (check 1):

13 ☐ Additional benefits

14 ☐ No change in benefits, but lower premiums

15 ☐ Fewer benefits and lower premiums

16 ☐ My plan has outpatient prescription drug coverage and
17 I am enrolling in part D

18 ☐ Disenrollment from a ~~medicare~~**MEDICARE** advantage
19 plan. Please explain reason for disenrollment. [Optional only for
20 direct mailers.]

21 ☐ Other. (Please specify)

22 1. Health conditions which you may presently have (pre-
23 existing conditions) may not be immediately or fully covered
24 under the new policy. This could result in denial or delay of a
25 claim for benefits under the new policy, whereas a similar claim
26 might have been payable under your present policy. This paragraph
27 may be deleted by an insurer if the replacement does not involve

1 application of a new pre-existing condition limitation.

2 2. Your insurer will waive any time periods applicable to
3 preexisting conditions, waiting periods, elimination periods, or
4 probationary periods in the new policy or certificate for similar
5 benefits to the extent such time was spent or depleted under the
6 original coverage. This paragraph may be deleted by an insurer if
7 the replacement does not involve application of a new preexisting
8 condition limitation.

9 3. If, after thinking about it carefully, you still wish to
10 drop your present coverage and replace it with new coverage, be
11 certain to truthfully and completely answer all questions on the
12 application concerning your medical and health history. Failure
13 to include all material medical information on an application may
14 provide a basis for the insurer to deny any future claims and to
15 refund your premium as though your policy or certificate had
16 never been in force. After the application has been completed,
17 and before you sign it, review it carefully to be certain that
18 all information has been properly recorded. (If the policy or
19 certificate is guaranteed issue, this paragraph need not appear.)

20 4. Do not cancel your present policy until you have received
21 your new policy and are sure that you want to keep it.

22 _____
23 Signature of Agent, Broker, or Other Representative
24 (* Signature not required for direct response sales.)

25 _____
26 Typed Name and Address of Agent or Broker

1

2 (Date)

3 The above "Notice to Applicant" was delivered to me on:

4

5 (Date)

6

7 (Applicant's Signature)

8

9 (Applicant's Printed Name)

10

11 (Applicant's Address)

12 (Policy, Certificate, or Contract Number being Replaced) "

13 Sec. 3829. (1) An insurer shall not deny or condition the
 14 issuance or effectiveness of a ~~medicare~~**MEDICARE** supplement
 15 policy available for sale in this state, or discriminate in the
 16 pricing of such a policy, because of the health status, claims
 17 experience, receipt of health care, or medical condition of an
 18 applicant if an application for the policy is submitted during
 19 the 6-month period beginning with the first month in which an
 20 individual who is 65 years of age or older ~~first~~-enrolled for
 21 benefits under ~~medicare~~**MEDICARE** part B. Each ~~medicare~~**MEDICARE**
 22 supplement policy currently available from an insurer ~~shall~~**MUST**
 23 be made available to all applicants who qualify under this
 24 section without regard to age.

(2) If an applicant qualifies under subsection (1), submits an application during the time period provided in subsection (1), and as of the date of application has had a continuous period of creditable coverage of not less than 6 months, the insurer shall not exclude benefits based on a preexisting condition. If the applicant qualifies under subsection (1), submits an application during the time period in subsection (1), and as of the date of application has had a continuous period of creditable coverage that is less than 6 months, the insurer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subsection.

(3) Except as provided in subsection (2) and section 3833, subsection (1) does not prevent the exclusion of benefits under a policy, during the first 6 months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the 6 months before the coverage became effective.

(4) ~~"Creditable"~~ **AS USED IN THIS SECTION, "CREDITABLE** coverage" does not include any of the following:

(a) One or more of the following:

- (i) Coverage only for accident or disability income insurance, or any combination of accident or disability income insurance.
- (ii) Coverage issued as a supplement to liability insurance.
- (iii) Liability insurance, including general liability

1 insurance and automobile liability insurance.

2 (iv) Workers' compensation or similar insurance.

3 (v) Automobile medical payment insurance.

4 (vi) Credit-only insurance.

5 (vii) Coverage for on-site medical clinics.

6 (viii) Other similar insurance coverage, specified in federal
7 regulations, under which benefits for medical care are secondary
8 or incidental to other insurance benefits.

9 (b) The following benefits if they are provided under a
10 separate policy, certificate, or contract of insurance or are
11 otherwise not an integral part of the plan:

12 (i) Limited scope dental or vision benefits.

13 (ii) Benefits for long-term care, nursing home care, home
14 health care, community-based care, or any combination of long-
15 term care, nursing home care, home health care, or community-
16 based care.

17 (iii) Such other similar, limited benefits as are specified in
18 federal regulations.

19 (c) The following benefits if offered as independent,
20 noncoordinated benefits:

21 (i) Coverage only for a specified disease or illness.

22 (ii) Hospital indemnity or other fixed indemnity insurance.

23 (d) The following if it is offered as a separate policy,
24 certificate, or contract of insurance:

25 (i) Medicare supplemental policy as defined ~~under section~~
26 ~~1882(g)(1) of part D of medicare, IN 42 U.S.C. USC 1395ss.~~

27 (ii) Coverage supplemental to the coverage provided under

1 chapter 55 of title 10 of the United States Code, 10 U.S.C. ~~USC~~
 2 1071 to ~~1109~~ **1110B**.

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

5 Sec. 3831. (1) Each insurer offering ~~individual or group~~
 6 expense incurred hospital, medical, or surgical policies or
 7 certificates in this state shall ~~provide~~ **MAKE AVAILABLE** without
 8 restriction, to any person who requests coverage from an insurer
 9 and has been insured with an insurer, ~~subject to this section, if~~
 10 the person ~~would no longer be insured because he or she has~~
 11 ~~become eligible for medicare or if the person loses coverage~~
 12 under a group policy after becoming eligible for ~~medicare,~~
 13 **MEDICARE**, a right of continuation or conversion to ~~their choice~~
 14 ~~of the basic core benefits as described in section 3807 or 3807a~~
 15 ~~or a type C medicare supplemental package as described in section~~
 16 ~~3811(5)(c) or 3811a(6)(c)~~ **1 OF THE FOLLOWING MEDICARE SUPPLEMENT**
 17 **PLANS** that is guaranteed renewable or noncancellable: -

18 (A) A POLICY FORM OR CERTIFICATE FORM THAT CONTAINS THE
 19 BASIC CORE BENEFITS AS DESCRIBED IN SECTION 3807 OR 3807A.

20 (B) A POLICY FORM OR CERTIFICATE FORM THAT THE INSURER HAS
 21 CHOSEN TO OFFER THAT CONTAINS EITHER STANDARDIZED BENEFIT PLAN C
 22 OR STANDARDIZED BENEFIT PLAN F. FOR AN INDIVIDUAL NEWLY ELIGIBLE
 23 FOR MEDICARE AFTER DECEMBER 31, 2019, ANY REFERENCE TO
 24 STANDARDIZED BENEFIT PLAN C OR STANDARDIZED BENEFIT PLAN F IS
 25 DEEMED A REFERENCE TO MEDICARE SUPPLEMENT STANDARDIZED BENEFIT
 26 PLAN D OR MEDICARE SUPPLEMENT STANDARDIZED BENEFIT PLAN G,
 27 RESPECTIVELY.

1 (2) A person who is hospitalized or has been informed by a
 2 physician that he or she will require hospitalization within 30
 3 days after the time of application ~~shall~~**IS** not ~~be~~ entitled to
 4 coverage under ~~this~~ subsection (1) until the day following the
 5 date of discharge. However, if the hospitalized person was
 6 insured by the insurer ~~immediately prior to becoming eligible for~~
 7 ~~medicare or immediately prior to~~**BEFORE** losing coverage under a
 8 group policy after becoming eligible for ~~medicare~~**MEDICARE**, the
 9 person ~~shall be~~**IS** eligible for immediate coverage from the
 10 previous insurer under ~~this~~ subsection (1). A person ~~shall~~**IS** not
 11 ~~be~~ entitled to a ~~medicare~~**MEDICARE** supplemental policy under ~~this~~
 12 subsection (1) unless the person presents satisfactory proof to
 13 the insurer that he or she was insured with an insurer subject to
 14 this section. A person who wishes coverage under ~~this~~ subsection
 15 (1) ~~must either request coverage within 90 days before or 90 days~~
 16 ~~after the month he or she becomes eligible for medicare or~~
 17 request coverage within 180 days after losing coverage under a
 18 group policy. A person 60 years of age or older who loses
 19 coverage under a group policy is entitled to coverage under a
 20 ~~medicare~~**MEDICARE** supplemental policy without restriction from
 21 the insurer providing the former group coverage, if he or she
 22 requests coverage within 90 days before or 90 days after the
 23 month he or she becomes eligible for ~~medicare~~**MEDICARE**.
 24 (3) ~~(2)~~ Except as provided in section 3833, a person not
 25 insured under ~~an individual or~~ **A** group hospital, medical, or
 26 surgical expense incurred policy as specified in subsection (1),
 27 after applying for coverage under a ~~medicare~~**MEDICARE**

1 supplemental policy required to be offered under subsection (1),
2 ~~shall be~~ **IS** entitled to coverage under a ~~medicare~~ **MEDICARE**
3 supplemental policy that may include a provision for exclusion
4 from preexisting conditions for 6 months after the inception of
5 coverage, consistent with the provisions of section 3819(2)(a) or
6 3819a(3)(a).

7 **(4)** ~~(3) Each insurer offering individual expense incurred~~
8 ~~hospital, medical, or surgical policies in this state shall give~~
9 ~~to each person who is insured with the insurer at the time he or~~
10 ~~she becomes eligible for medicare, and to each applicant of the~~
11 ~~insurer who is eligible for medicare, written notice of the~~
12 ~~availability of coverage under this section. Each group~~
13 ~~policyholder providing hospital, medical, or surgical expense~~
14 ~~incurred coverage in this state shall give to each certificate~~
15 ~~holder who is covered at the time he or she becomes eligible for~~
16 ~~medicare, **MEDICARE**, written notice of the availability of~~
17 ~~coverage under this section.~~

18 **(5)** ~~(4)~~ Notwithstanding the requirements of this section, an
19 insurer offering or renewing ~~individual or group~~ expense incurred
20 hospital, medical, or surgical policies or certificates after
21 June 27, 2005 may comply with the requirement of providing
22 ~~medicare~~ **MEDICARE** supplemental coverage to eligible policyholders
23 by utilizing another insurer to write this coverage ~~provided~~ **IF**
24 the insurer meets all of the following requirements:

25 (a) The insurer provides its policyholders the name of the
26 insurer that will provide the ~~medicare~~ **MEDICARE** supplemental
27 coverage.

(b) The insurer gives its policyholders the telephone numbers at which the ~~medicare~~**MEDICARE** supplemental insurer can be reached.

(c) The insurer remains responsible for providing ~~medicare~~**MEDICARE** supplemental coverage to its policyholders ~~in the event that~~**IF** the other insurer no longer provides coverage and another insurer is not found to take its place.

(d) The insurer provides certification from an executive officer for the specific insurer or affiliate of the insurer wishing to utilize this option. This certification ~~shall~~**MUST** identify the process provided in subdivisions (a) ~~through~~**TO** (c) and ~~shall~~**MUST** clearly state that the insurer understands that the ~~commissioner~~**DIRECTOR** may void this arrangement if the affiliate fails to ensure that eligible policyholders are immediately offered ~~medicare~~**MEDICARE** supplemental policies.

(e) ~~The~~**IF THE INSURER IS UNABLE TO MEET THE REQUIREMENTS OF SUBDIVISIONS (A) TO (D), THE** insurer certifies to the ~~commissioner~~**DIRECTOR** that it is in the process of discontinuing in ~~Michigan~~**THIS STATE** its offering of individual or group expense incurred hospital, medical, or surgical policies or certificates.

Sec. 3835. (1) ~~Each~~**AN** insurer ~~marketing medicare~~**THAT MARKETS MEDICARE** supplement insurance coverage in this state directly or through its agents shall do all of the following:

(a) Establish marketing procedures to ensure that any comparison of policies by its agents will be fair and accurate.

(b) Establish marketing procedures to ensure excessive

1 insurance is not sold or issued.

2 (c) Inquire and otherwise make every reasonable effort to
3 identify whether a prospective applicant for ~~medicare~~**MEDICARE**
4 supplement insurance already has ~~disability or other health~~
5 coverage. ~~and the types and amounts of coverage.~~

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

8 (2) In recommending the purchase or replacement of any
9 ~~medicare~~**MEDICARE** supplement coverage, an agent shall make
10 reasonable efforts to determine the appropriateness of a
11 recommended purchase or replacement.

12 (3) Any sale of ~~medicare~~**MEDICARE** supplement coverage that
13 will provide an individual with more than 1 ~~medicare~~**MEDICARE**
14 supplement policy, certificate, or contract is prohibited.

15 (4) An insurer shall not issue a ~~medicare~~**MEDICARE**
16 supplement policy or certificate to an individual enrolled in
17 ~~medicare~~**MEDICARE** advantage unless the effective date of the
18 coverage is after the termination date of the individual's
19 ~~medicare~~**MEDICARE** advantage coverage.

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

24 Sec. 3843. (1) ~~Any~~**A** policy or certificate of ~~disability~~
25 **HEALTH** insurance issued for delivery in this state to persons
26 eligible for ~~medicare~~**MEDICARE** by reason of age ~~shall~~**MUST** notify
27 insureds under the policy or certificate that the policy is not a

~~medicare~~**MEDICARE** supplement policy. The notice ~~shall~~**MUST** either be printed or attached to the first page of the coverage outline delivered to insureds under the policy or certificate ~~or~~, if a coverage outline is not delivered, to the first page of the policy or certificate delivered to insureds. The notice ~~shall~~**MUST** be in not less than 12-point type, and ~~shall~~**MUST** contain the following language:

"This (policy or certificate) is not a ~~medicare~~**MEDICARE** supplement (policy or certificate). It is not designed to fit with ~~medicare~~**MEDICARE**. It may not fit all of the gaps in ~~medicare~~**MEDICARE** and it may duplicate some ~~medicare~~**MEDICARE** benefits. If you are eligible for ~~medicare~~**MEDICARE**, review the ~~medicare~~**MEDICARE** supplement buyer's guide available from the company. If you decide to consider buying this policy or certificate, be sure you understand what it covers, what it does not cover, and whether it duplicates coverage you already have."

(2) Subsection (1) does not apply to any of the following:

(a) A ~~medicare~~**MEDICARE** supplement policy or certificate.

(b) A disability income policy or certificate.

(c) A single premium nonrenewable policy or certificate.

Sec. 3847. ~~Each~~**AN** insurer ~~providing medicare~~**THAT PROVIDES** **MEDICARE** supplement insurance coverage in this state shall file with the ~~commissioner~~**DIRECTOR** for review a copy of any written, radio, or television advertisement for ~~medicare~~**MEDICARE** supplement insurance intended for use in this state at least ~~45~~**30** days before the date the insurer desires to use the advertising. The filing ~~shall~~**MUST** include a sample or photocopy

1 of all applicable ~~medicare~~**MEDICARE** supplement policies and
2 related forms and the approval status of the policies and forms.

3 Enacting section 1. Sections 3804 and 3808 of the insurance
4 code of 1956, 1956 PA 218, MCL 500.3804 and 500.3808, are
5 repealed.

6 Enacting section 2. This amendatory act takes effect 90 days
7 after the date it is enacted into law.