

**SUBSTITUTE FOR  
HOUSE BILL NO. 6359**

[A bill to amend 1956 PA 218, entitled  
"The insurance code of 1956,"  
by amending sections 3801, 3805, 3807, 3809, 3811, 3815, 3817,  
3819, 3823, 3827, 3830, 3831, 3835, 3839, 3841, and 3849 (MCL 500.3801,  
500.3805, 500.3807, 500.3809, 500.3811, 500.3815, 500.3817,  
500.3819, 500.3823, 500.3827, 500.3830, 500.3831, 500.3835, 500.3839,  
500.3841, and 500.3849), sections 3801, 3807, 3809, 3811, 3815,  
and 3819 as amended and section 3830 as added by 2002 PA 304 and  
sections 3805, 3817, 3823, 3827, 3831, 3835, 3839, 3841, and 3849 as  
added by 1992 PA 84, and by adding section 3804; and to repeal  
acts and parts of acts.]

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

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

1 who seeks to contract for ~~insurance~~ benefits.

2 (ii) For a group medicare supplement policy **OR CERTIFICATE**,  
3 the proposed certificate holder.

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

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

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

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

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

19 (i) A group health plan.

20 (ii) Health insurance coverage.

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

22 (iv) Medicaid other than coverage consisting solely of  
23 benefits under section 1928 of medicaid, 42 ~~U.S.C.~~ **USC** 1396s.

24 (v) Chapter 55 of title 10 of the United States Code, 10  
25 ~~U.S.C.~~ **USC** 1071 to 1110.

26 (vi) A medical care program of the Indian health service or  
27 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 ~~U.S.C.~~ **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, ~~Public Law 87-293,~~ 22 ~~U.S.C.~~ **USC** 2504.

(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, ~~Public Law 93-406,~~ 29 ~~U.S.C.~~ **USC** 1002.

(i) "Insolvency" means when an insurer licensed to transact the business of insurance in this state 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 or issuing for delivery in this state medicare supplement policies.

(k) "Medicaid" means title XIX of the social security act, ~~chapter 531, 49 Stat. 620,~~ 42 ~~U.S.C.~~ **USC** 1396 to ~~1396r-6 and~~

1 ~~1396r-8 to 1396v.~~

2 (l) "Medicare" means title XVIII of the social security act,  
 3 ~~chapter 531, 49 Stat. 620, 42 U.S.C. USC 1395 to 1395b,~~  
 4 ~~1395b-2, 1395b-6 to 1395b-7, 1395c to 1395i, 1395i-2 to 1395i-5,~~  
 5 ~~1395j to 1395t, 1395u to 1395w, 1395w-2 to 1395w-4, 1395w-21 to~~  
 6 ~~1395w-28, 1395x to 1395yy, and 1395bbb to 1395ggg.~~

7 (m) ~~"Medicare+choice plan"~~ **"MEDICARE ADVANTAGE"** means a  
 8 plan of coverage for health benefits under medicare part C as  
 9 defined in section 12-2859 of part C of medicare, 42 ~~U.S.C. USC~~  
 10 1395w-28, and includes any of the following:

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

16 (ii) Medical savings account plans coupled with a  
 17 contribution into a ~~medicare+choice~~ **MEDICARE ADVANTAGE** medical  
 18 savings account.

19 (iii) ~~Medicare+choice~~ **MEDICARE ADVANTAGE** private fee-for-  
 20 service plans.

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

26 (o) "Medicare supplement policy" means an individual,  
 27 **NONGROUP**, or group policy or certificate ~~of insurance~~ that is

1 advertised, marketed, or designed primarily as a supplement to  
 2 reimbursements under medicare for the hospital, medical, or  
 3 surgical expenses of persons eligible for medicare and medicare  
 4 select policies and certificates under section 3817. Medicare  
 5 supplement policy does not include a policy, **CERTIFICATE**, or  
 6 contract of 1 or more employers or labor organizations, or of the  
 7 trustees of a fund established by 1 or more employers or labor  
 8 organizations, or both, for employees or former employees, or  
 9 both, or for members or former members, or both, of the labor  
 10 organizations. **MEDICARE SUPPLEMENT POLICY DOES NOT INCLUDE**  
 11 **MEDICARE ADVANTAGE PLANS ESTABLISHED UNDER MEDICARE PART C,**  
 12 **OUTPATIENT PRESCRIPTION DRUG PLANS ESTABLISHED UNDER MEDICARE**  
 13 **PART D, OR ANY HEALTH CARE PREPAYMENT PLAN THAT PROVIDES BENEFITS**  
 14 **PURSUANT TO AN AGREEMENT UNDER SECTION 1833(A)(1)(A) OF THE**  
 15 **SOCIAL SECURITY ACT.**

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

18 (q) "Policy form" means the form on which the policy **OR**  
 19 **CERTIFICATE** is delivered or issued for delivery by the insurer.

20 (r) "Secretary" means the secretary of the United States  
 21 department of health and human services.

22 (s) "Social security act" means the social security act,  
 23 ~~chapter 531, 49 Stat. 620~~ **42 USC 301 TO 1397JJ.**

24 **SEC. 3804. THIS CHAPTER APPLIES TO A MEDICARE SUPPLEMENT**  
 25 **POLICY DELIVERED, ISSUED FOR DELIVERY, OR RENEWED BY A HEALTH**  
 26 **CARE CORPORATION OPERATING PURSUANT TO THE NONPROFIT HEALTH CARE**  
 27 **CORPORATION REFORM ACT, 1980 PA 350, MCL 550.1101 TO 550.1704, ON**

1 **OR AFTER THE EFFECTIVE DATE OF THIS SECTION.**

2 Sec. 3805. As used in a medicare supplement policy:

3 (a) The definition of "accident", "accidental injury", or  
4 "accidental means" shall not include words that establish an  
5 accidental means test or use words such as "external, violent,  
6 visible wounds" or similar words of description or  
7 characterization. The definition may provide that injuries shall  
8 not include injuries for which benefits are provided or available  
9 under any worker's compensation, employer's liability or similar  
10 law, or motor vehicle no-fault plan, unless prohibited by law.

11 (b) The definition of "benefit period" or "medicare benefit  
12 period" shall not be defined in a more restrictive manner than as  
13 defined in medicare.

14 (c) "Hospital" may be defined in relation to its status,  
15 facilities, and available services or to reflect its  
16 accreditation by the joint commission on accreditation of  
17 hospitals, but not more restrictively than as defined in  
18 medicare.

19 (d) The definition of "medicare eligible expenses" shall  
20 mean health care expenses of the kinds covered by **PART A AND PART**  
21 **B OF** medicare, to the extent recognized as reasonable and  
22 medically necessary by medicare.

23 (e) "Nurses" may be defined so that the description of nurse  
24 is to a type of nurse, such as a registered professional nurse or  
25 a licensed practical nurse. If the words "nurse", "trained  
26 nurse", or "registered nurse" are used without specific  
27 instruction, then the use of those terms requires the insurer to

1 recognize the services of any individual who qualifies under  
2 those terms in accordance with the public health code, ~~Act No.~~  
3 ~~368 of the Public Acts of 1978, being sections 333.1101 to~~  
4 ~~333.25211 of the Michigan Compiled Laws~~ **1978 PA 368, MCL**  
5 **333.1101 TO 333.25211.**

6 (f) "Physician" shall not be defined more restrictively than  
7 as defined in medicare.

8 (g) "Sickness" shall not be defined more restrictively than  
9 to mean illness or disease of an insured person that first  
10 manifests itself after the effective date of insurance and while  
11 the insurance is in force. The definition may be further modified  
12 to exclude sicknesses or diseases for which benefits are provided  
13 to the insured under any worker's compensation, occupational  
14 disease, employer's liability, or similar law.

15 (h) "Skilled nursing facility" shall not be defined more  
16 restrictively than as defined in medicare.

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

26 (a) Coverage of part A medicare eligible expenses for  
27 hospitalization to the extent not covered by medicare from the

1 61st day through the 90th day in any medicare benefit period.

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

5 (c) Upon exhaustion of the medicare hospital inpatient  
6 coverage including the lifetime reserve days, coverage of **100% OF**  
7 the medicare part A eligible expenses for hospitalization paid at  
8 the ~~diagnostic related group day outlier per diem~~ **APPLICABLE**  
9 **PROSPECTIVE PAYMENT SYSTEM RATE** or other appropriate **MEDICARE**  
10 standard of payment, subject to a lifetime maximum benefit of an  
11 additional 365 days.

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

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

21 **(2) STANDARDS FOR PLANS K AND L ARE AS FOLLOWS:**

22 **(A) STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN K SHALL**  
23 **CONSIST OF THE FOLLOWING:**

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

27 **(ii) COVERAGE OF 100% OF THE PART A HOSPITAL COINSURANCE**



1 AMOUNT FOR EACH MEDICARE LIFETIME INPATIENT RESERVE DAY USED FROM  
2 THE NINETY-FIRST DAY THROUGH THE ONE HUNDRED FIFTIETH DAY IN ANY  
3 MEDICARE BENEFIT PERIOD.

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

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

16 (v) SKILLED NURSING FACILITY CARE: COVERAGE FOR 50% OF THE  
17 COINSURANCE AMOUNT FOR EACH DAY USED FROM THE TWENTY-FIRST DAY  
18 THROUGH THE ONE HUNDREDTH DAY IN A MEDICARE BENEFIT PERIOD FOR  
19 POSTHOSPITAL SKILLED NURSING FACILITY CARE ELIGIBLE UNDER  
20 MEDICARE PART A UNTIL THE OUT-OF-POCKET LIMITATION IS MET AS  
21 DESCRIBED IN SUBPARAGRAPH (x).

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

25 (vii) COVERAGE FOR 50%, UNDER MEDICARE PART A OR B, OF THE  
26 REASONABLE COST OF THE FIRST 3 PINTS OF BLOOD OR EQUIVALENT  
27 QUANTITIES OF PACKED RED BLOOD CELLS, AS DEFINED UNDER FEDERAL

1 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) BELOW,  
5 COVERAGE FOR 50% OF THE COST SHARING OTHERWISE APPLICABLE UNDER  
6 MEDICARE PART B AFTER THE POLICYHOLDER PAYS THE PART B DEDUCTIBLE  
7 UNTIL THE OUT-OF-POCKET LIMITATION IS MET AS DESCRIBED IN  
8 SUBPARAGRAPH (x).

9 (ix) COVERAGE OF 100% OF THE COST SHARING FOR MEDICARE PART B  
10 PREVENTIVE SERVICES AFTER THE POLICYHOLDER PAYS THE PART B  
11 DEDUCTIBLE.

12 (x) COVERAGE OF 100% OF ALL COST SHARING UNDER MEDICARE  
13 PARTS A AND B FOR THE BALANCE OF THE CALENDAR YEAR AFTER THE  
14 INDIVIDUAL HAS REACHED THE OUT-OF-POCKET LIMITATION ON ANNUAL  
15 EXPENDITURES UNDER MEDICARE PARTS A AND B OF \$4,000.00 IN 2006,  
16 INDEXED EACH YEAR BY THE APPROPRIATE INFLATION ADJUSTMENT  
17 SPECIFIED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF  
18 HEALTH AND HUMAN SERVICES.

19 (B) STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN L SHALL  
20 CONSIST OF THE FOLLOWING:

21 (i) THE BENEFITS DESCRIBED IN SUBDIVISION (A)(i), (ii), (iii),  
22 AND (ix).

23 (ii) THE BENEFIT DESCRIBED IN SUBDIVISION (A)(iv), (v), (vi),  
24 (vii), AND (viii), BUT SUBSTITUTING 75% FOR 50%.

25 (iii) THE BENEFIT DESCRIBED IN SUBDIVISION (A)(x), BUT  
26 SUBSTITUTING \$2,000.00 FOR \$4,000.00.

27 Sec. 3809. (1) In addition to the basic core package of

1 benefits required under section 3807, the following benefits may  
2 be included in a medicare supplement insurance policy and if  
3 included shall conform to section 3811(5)(b) to (j):

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

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

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

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

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

25 (f) Basic outpatient prescription drug benefit: coverage for  
26 50% of outpatient prescription drug charges, after a \$250.00  
27 calendar year deductible, to a maximum of \$1,250.00 in benefits

1 received by the insured per calendar year, to the extent not  
2 covered by medicare. **THE OUTPATIENT PRESCRIPTION DRUG BENEFIT MAY**  
3 **BE INCLUDED FOR SALE OR ISSUANCE IN A MEDICARE SUPPLEMENT POLICY**  
4 **UNTIL JANUARY 1, 2006.**

5 (g) Extended outpatient prescription drug benefit: coverage  
6 for 50% of outpatient prescription drug charges, after a \$250.00  
7 calendar year deductible, to a maximum of \$3,000.00 in benefits  
8 received by the insured per calendar year, to the extent not  
9 covered by medicare. **THE OUTPATIENT PRESCRIPTION DRUG BENEFIT MAY**  
10 **BE INCLUDED FOR SALE OR ISSUANCE IN A MEDICARE SUPPLEMENT POLICY**  
11 **UNTIL JANUARY 1, 2006.**

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

24 (i) Preventive medical care benefit: Coverage for the  
25 following preventive health services **NOT COVERED BY MEDICARE:**

26 (i) An annual clinical preventive medical history and  
27 physical examination that may include tests and services from

subparagraph (ii) and patient education to address preventive health care measures.

(ii) ~~Any 1 or a combination of the following preventive~~  
**PREVENTIVE** screening tests or preventive services, the **SELECTION**  
**AND** frequency of which is ~~considered~~ **DETERMINED TO BE** medically  
 appropriate ~~—~~ **BY THE ATTENDING PHYSICIAN.**

~~—— (A) Digital rectal examination.~~

~~—— (B) Dipstick urinalysis for hematuria, bacteriuria, and  
 proteinuria.~~

~~—— (C) Pure tone, air only, hearing screening test,  
 administered or ordered by a physician.~~

~~—— (D) Serum cholesterol screening every 5 years.~~

~~—— (E) Thyroid function test.~~

~~—— (F) Diabetes screening.~~

~~—— (G) Tetanus and diphtheria booster every 10 years.~~

~~—— (H) Any other tests or preventive measures determined  
 appropriate by the attending physician.~~

(j) At-home recovery benefit: coverage for services to  
 provide short term, at-home assistance with activities of daily  
 living for those recovering from an illness, injury, or surgery.  
 At-home recovery services provided shall be primarily services  
 that assist in activities of daily living. The insured's  
 attending physician shall certify that the specific type and  
 frequency of at-home recovery services are necessary because of a  
 condition for which a home care plan of treatment was approved by  
 medicare. Coverage is excluded for home care visits paid for by  
 medicare or other government programs and care provided by family

members, unpaid volunteers, or providers who are not care providers. Coverage is limited to:

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

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

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

(iv) Seven visits in any 1 week.

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

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

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

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

(k) New or innovative benefits: an insurer may, with the prior approval of the commissioner, 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. ~~These~~ **THE NEW OR INNOVATIVE** benefits may include benefits that are appropriate to

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 supplement  
4 policies. **AFTER DECEMBER 31, 2005, THE INNOVATIVE BENEFIT SHALL**  
5 **NOT INCLUDE AN OUTPATIENT PRESCRIPTION DRUG BENEFIT.**

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

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

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

19 (b) "Care provider" means a duly qualified or licensed home  
20 health aide/homemaker, personal care aide, or nurse provided  
21 through a licensed home health care agency or referred by a  
22 licensed referral agency or licensed nurses registry.

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

27 (d) "At-home recovery visit" means the period of a visit

1 required to provide at home recovery care, without limit on the  
2 duration of the visit, except each consecutive 4 hours in a 24-  
3 hour period of services provided by a care provider is 1 visit.

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

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

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

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

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

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



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

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

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

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

23 (f) A standardized medicare supplement benefit plan F shall  
24 include only the following: the core benefits as defined in  
25 section 3807, the medicare part A deductible, skilled nursing  
26 facility care, medicare part B deductible, 100% of the medicare  
27 part B excess charges, and medically necessary emergency care in

1 a foreign country as defined in section 3809(1)(a), (b), (c),  
2 (e), and (h). A standardized medicare supplement plan F high  
3 deductible shall include only the following: 100% of covered  
4 expenses following the payment of the annual high deductible plan  
5 F deductible. The covered expenses include the core benefits as  
6 defined in section 3807, plus the medicare part A deductible,  
7 skilled nursing facility care, the medicare part B deductible,  
8 100% of the medicare part B excess charges, and medically  
9 necessary emergency care in a foreign country as defined in  
10 section 3809(1)(a), (b), (c), (e), and (h). The annual high  
11 deductible plan F deductible shall consist of out-of-pocket  
12 expenses, other than premiums, for services covered by the  
13 medicare supplement plan F policy, and shall be in addition to  
14 any other specific benefit deductibles. The annual high  
15 deductible plan F deductible is ~~-\$1,580.00~~ **\$1,790.00** for  
16 calendar year ~~2001~~ **2006**, and the secretary shall adjust it  
17 annually thereafter to reflect the change in the consumer price  
18 index for all urban consumers for the 12-month period ending with  
19 August of the preceding year, rounded to the nearest multiple of  
20 \$10.00.

21 (g) A standardized medicare supplement benefit plan G shall  
22 include only the following: the core benefits as defined in  
23 section 3807, the medicare part A deductible, skilled nursing  
24 facility care, 80% of the medicare part B excess charges,  
25 medically necessary emergency care in a foreign country, and the  
26 at-home recovery benefit as defined in section 3809(1)(a), (b),  
27 (d), (h), and (j).

(h) A standardized medicare supplement benefit plan H shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (f), and (h). **THE OUTPATIENT DRUG BENEFIT SHALL NOT BE INCLUDED IN A MEDICARE SUPPLEMENT POLICY SOLD AFTER DECEMBER 31, 2005.**

(i) A standardized medicare supplement benefit plan I shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, 100% of the medicare part B excess charges, basic outpatient prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in section 3809(1)(a), (b), (e), (f), (h), and (j). **THE OUTPATIENT DRUG BENEFIT SHALL NOT BE INCLUDED IN A MEDICARE SUPPLEMENT POLICY SOLD AFTER DECEMBER 31, 2005.**

(j) A standardized medicare supplement benefit plan J shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in section 3809(1)(a), (b), (c), (e), (g), (h), (i), and (j). A standardized medicare supplement benefit plan J high deductible plan shall consist of only the following: 100% of covered

1 expenses following the payment of the annual high deductible plan  
 2 J deductible. The covered expenses include the core benefits as  
 3 defined in section 3807, plus the medicare part A deductible,  
 4 skilled nursing facility care, medicare part B deductible, 100%  
 5 of the medicare part B excess charges, extended outpatient  
 6 prescription drug benefit, medically necessary emergency care in  
 7 a foreign country, preventive medical care benefit and at-home  
 8 recovery benefit as defined in section 3809(1)(a), (b), (c), (e),  
 9 (g), (h), (i), and (j). The annual high deductible plan J  
 10 deductible shall consist of out-of-pocket expenses, other than  
 11 premiums, for services covered by the medicare supplement plan J  
 12 policy, and shall be in addition to any other specific benefit  
 13 deductibles. The annual deductible shall be ~~\$1,580.00~~ **\$1,790.00**  
 14 for calendar year ~~2001~~ **2006**, and the secretary shall adjust it  
 15 annually thereafter to reflect the change in the consumer price  
 16 index for all urban consumers for the 12-month period ending with  
 17 August of the preceding year, rounded to the nearest multiple of  
 18 \$10.00. **THE OUTPATIENT DRUG BENEFIT SHALL NOT BE INCLUDED IN A**  
 19 **MEDICARE SUPPLEMENT POLICY SOLD AFTER DECEMBER 31, 2005.**

20 **(K) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN K SHALL**  
 21 **CONSIST OF ONLY THOSE BENEFITS DESCRIBED IN SECTION 3807(2)(A).**

22 **(L) A STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN L SHALL**  
 23 **CONSIST OF ONLY THOSE BENEFITS DESCRIBED IN SECTION 3807(2)(B).**

24 Sec. 3815. (1) An insurer that offers a medicare supplement  
 25 policy shall provide to the applicant at the time of application  
 26 an outline of coverage and, except for direct response  
 27 solicitation policies, shall obtain an acknowledgment of receipt

of the outline of coverage from the applicant. The outline of coverage provided to applicants pursuant to this section shall consist of the following 4 parts:

(a) A cover page.

(b) Premium information.

(c) Disclosure pages.

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

**(2) INSURERS SHALL COMPLY WITH ANY NOTICE REQUIREMENTS OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003, PUBLIC LAW 108-173.**

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

NOTICE: Read this outline of coverage carefully.

It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.

**(4)** ~~(3)~~ An outline of coverage under subsection (1) shall be in the language and format prescribed in this section and in not less than 12-point type. The A through ~~J~~ L letter designation of the plan shall be shown on the cover page and the

1 plans offered by the insurer shall be prominently identified.  
 2 Premium information shall be shown on the cover page or  
 3 immediately following the cover page and shall be prominently  
 4 displayed. The premium and method of payment mode shall be stated  
 5 for all plans that are offered to the applicant. All possible  
 6 premiums for the applicant shall be illustrated. The following  
 7 items shall be included in the outline of coverage in the order  
 8 prescribed below and in substantially the following form, as  
 9 approved by the commissioner:

10 (Insurer Name)  
 11 Medicare Supplement Coverage  
 12 Outline of Medicare Supplement Coverage-Cover Page:  
 13 Benefit Plan(s)\_\_\_\_\_ [insert letter(s) of plan(s) being offered]  
 14 Medicare supplement insurance can be sold in only ~~10~~ 12  
 15 standard plans plus 2 high deductible plans. This chart shows  
 16 the benefits included in each plan. Every insurer shall make  
 17 available Plan "A". Some plans may not be available in your  
 18 state.  
 19 **BASIC BENEFITS: ~~Included in All Plans.~~ FOR PLANS A-J.**  
 20 Hospitalization: Part A coinsurance plus coverage for 365  
 21 additional days after Medicare benefits end.  
 22 Medical Expenses: Part B coinsurance (20% of Medicare-approved  
 23 expenses) or ~~, for hospital outpatient department services~~  
 24 ~~under a prospective payment system, applicable~~ copayments  
 25 **FOR HOSPITAL OUTPATIENT SERVICES.**  
 26 Blood: First three pints of blood each year.

		A	B	C	D	E	F F*	G	H	I	J J*
1											
2	Basic Benefits	X	X	X	X	X	X	X	X	X	X
3	Skilled Nursing										
4	Co-Insurance			X	X	X	X	X	X	X	X
5	Part A Deductible		X	X	X	X	X	X	X	X	X
6	Part B Deductible			X			X				X
7	Part B Excess						X	X		X	X
8							100%	80%		100%	100%
9	Foreign Travel										
10	Emergency			X	X	X	X	X	X	X	X
11	At-Home Recovery				X			X		X	X
12											
13	Drugs								X	X	X
14									\$1,250 Limit	\$1,250 Limit	\$3,000 Limit
15	Preventive Care <b>NOT COVERED BY MEDICARE</b>					X					X

1 [COMPANY NAME]

2 OUTLINE OF MEDICARE SUPPLEMENT COVERAGE - COVER PAGE 2

3 BASIC BENEFITS FOR PLANS K AND L INCLUDE SIMILAR SERVICES AS PLANS A-J, BUT COST-SHARING  
 4 FOR THE BASIC BENEFITS IS AT DIFFERENT LEVELS.



1		K**	L**
2		100% OF PART A HOSPITALIZA- TION COINSURANCE PLUS COVERAGE FOR 365 DAYS AFTER MEDICARE BENEFITS END	100% OF PART A HOSPITALIZA- TION COINSURANCE PLUS COVERAGE FOR 365 DAYS AFTER MEDICARE BENEFITS END
3			
4			
5			
6	BASIC BENEFITS	50% HOSPICE COST-SHARING	75% HOSPICE COST-SHARING
7		50% OF MEDICARE-ELIGIBLE EXPENSES FOR THE FIRST THREE PINTS OF BLOOD	75% OF MEDICARE-ELIGIBLE EXPENSES FOR THE FIRST THREE PINTS OF BLOOD
8			
9			
10		50% PART B COINSURANCE, EXCEPT 100% COINSURANCE FOR PART B PREVENTIVE SERVICES	75% PART B COINSURANCE, EXCEPT 100% COINSURANCE FOR PART B PREVENTIVE SERVICES
11			
12			
13	SKILLED NURSING	50% SKILLED NURSING	75% SKILLED NURSING
14	COINSURANCE	FACILITY COINSURANCE	FACILITY COINSURANCE
15	PART A DEDUCTIBLE	50% PART A DEDUCTIBLE	75% PART A DEDUCTIBLE
16	PART B DEDUCTIBLE		
17	PART B EXCESS (100%)		
18	FOREIGN TRAVEL		
19	EMERGENCY		
20	AT-HOME RECOVERY		
21	PREVENTIVE CARE NOT		

1	COVERED BY MEDICARE		
2		\$4,000 OUT OF POCKET ANNUAL LIMIT***	\$2,000 OUT OF POCKET ANNUAL LIMIT***
3			

1 \*PLANS F AND J ALSO HAVE AN OPTION CALLED A HIGH DEDUCTIBLE PLAN  
 2 F AND A HIGH DEDUCTIBLE PLAN J. THESE HIGH DEDUCTIBLE PLANS PAY  
 3 THE SAME BENEFITS AS PLANS F AND J AFTER ONE HAS PAID A CALENDAR  
 4 YEAR (\$1,790) DEDUCTIBLE. BENEFITS FROM HIGH DEDUCTIBLE PLANS F  
 5 AND J WILL NOT BEGIN UNTIL OUT-OF-POCKET EXPENSES EXCEED  
 6 (\$1,790). OUT-OF-POCKET EXPENSES FOR THIS DEDUCTIBLE ARE EXPENSES  
 7 THAT WOULD ORDINARILY BE PAID BY THE POLICY. THESE EXPENSES  
 8 INCLUDE THE MEDICARE DEDUCTIBLES FOR PART A AND PART B, BUT DO  
 9 NOT INCLUDE THE PLAN'S SEPARATE FOREIGN TRAVEL EMERGENCY  
 10 DEDUCTIBLE.

11 \*\* PLANS K AND L PROVIDE FOR DIFFERENT COST-SHARING FOR ITEMS AND  
 12 SERVICES THAN PLANS A-J.

13 ONCE YOU REACH THE ANNUAL LIMIT, THE PLAN PAYS 100% OF THE  
 14 MEDICARE COPAYMENTS, COINSURANCE, AND DEDUCTIBLES FOR THE REST OF  
 15 THE CALENDAR YEAR. THE OUT-OF-POCKET ANNUAL LIMIT DOES NOT  
 16 INCLUDE CHARGES FROM YOUR PROVIDER THAT EXCEED MEDICARE-APPROVED  
 17 AMOUNTS, CALL "EXCESS CHARGES". YOU WILL BE RESPONSIBLE FOR  
 18 PAYING EXCESS CHARGES.

19 \*\*\* THE OUT-OF-POCKET ANNUAL LIMIT WILL INCREASE EACH YEAR FOR  
 20 INFLATION.

21 SEE OUTLINES OF COVERAGE FOR DETAILS AND EXCEPTIONS.

## 22 PREMIUM INFORMATION

23 We (insert insurer's name) can only raise your premium if we  
 24 raise the premium for all policies like yours in this state. (If  
 25 the premium is based on the increasing age of the insured,

1 include information specifying when premiums will change).

2 DISCLOSURES

3 Use this outline to compare benefits and premiums among  
4 policies, certificates, and contracts.

5 READ YOUR POLICY VERY CAREFULLY

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

10 RIGHT TO RETURN POLICY

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

16 POLICY REPLACEMENT

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

20 NOTICE

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

2        [For agent issued policies]

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

5        [For direct response issued policies]

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

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

10                    COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

19        [Include for each plan offered by the insurer a chart  
20 showing the services, medicare payments, plan payments, and  
21 insured payments using the same language, in the same order, and  
22 using uniform layout and format as shown in the charts that  
23 follow. An insurer may use additional benefit plan designations  
24 on these charts pursuant to section 3809(1)(k). Include an  
25 explanation of any innovative benefits on the cover page and in

1 the chart, in a manner approved by the commissioner. The insurer  
 2 issuing the policy shall change the dollar amounts each year to  
 3 reflect current figures. No more than 4 plans may be shown on 1  
 4 chart.] Charts for each plan are as follows:

5 PLAN A

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

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

11	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
12	HOSPITALIZATION*			
13	Semiprivate room and			
14	board, general nursing			
15	and miscellaneous			
16	services and supplies			
17	First 60 days	All but <del>\$792</del> <b>\$952</b>	\$0	<del>\$792—</del> <b>\$952</b> (Part A Deductible)
18				
19	61st thru 90th day	All but <del>\$198</del> <b>\$238</b>	<del>\$198—</del> <b>\$238</b>	\$0
20		a day	a day	
21	91st day and after:			
22	—While using 60			
23	lifetime reserve days	All but <del>\$396</del> <b>\$476</b>	<del>\$396—</del> <b>\$476</b>	\$0
24		a day	a day	
25	—Once lifetime reserve			

1	days are used:			
2	–Additional 365 days	\$0	100% of	\$0
3			Medicare	
4			Eligible	
5			Expenses	
6	–Beyond the			
7	Additional 365 days	\$0	\$0	All Costs
8	SKILLED NURSING FACILITY			
9	CARE*			
10	You must meet Medicare's			
11	requirements, including			
12	having been in a hospital			
13	for at least 3 days and			
14	entered a Medicare-			
15	approved facility within			
16	30 days after leaving the			
17	hospital			
18	First 20 days	All approved		
19		amounts	\$0	\$0
20	21st thru 100th day	All but <del>\$99</del> <b>\$119</b>	\$0	Up to <del>\$99</del> <b>\$119</b>
21		a day		a day
22	101st day and after	\$0	\$0	All costs
23	BLOOD			
24	First 3 pints	\$0	3 pints	\$0
25	Additional amounts	100%	\$0	\$0
26	HOSPICE CARE			
27	Available as long as your	All but very	\$0	Balance
28	doctor certifies you are	limited		
29	terminally ill and you	coinsurance		
30	elect to receive these	for outpatient		

1	services	drugs and		
2		inpatient		
3		respite care		

4 PLAN A

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

6 \*Once you have been billed ~~—\$100—~~ **\$124** of Medicare-Approved  
7 amounts for covered services (which are noted with an asterisk),  
8 your Part B Deductible will have been met for the calendar year.

9	SERVICES	MEDICARE PAYS	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 <del>\$100</del> <b>\$124</b> of Medicare			
23	Approved Amounts*	\$0	\$0	<del>\$100—</del> <b>\$124</b> (Part B Deductible)
24				
25	Remainder of Medicare			
26	Approved Amounts	80%	20%	\$0
27	Part B Excess Charges			



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

14 PARTS A & B

15	HOME HEALTH CARE			
16	Medicare Approved			
17	Services			
18	—Medically necessary			
19	skilled care services			
20	and medical supplies	100%	\$0	\$0
21	—Durable medical			
22	equipment			
23	First <del>\$100</del> <b>\$124</b> of Medicare			
24	Approved Amounts*	\$0	\$0	<del>\$100</del> <b>\$124</b> (Part B Deductible)
25				
26	Remainder of Medicare			
27	Approved Amounts	80%	20%	\$0

## PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but <del>\$792</del> <b>\$952</b>	<del>\$792—</del> <b>\$952</b> (Part A Deductible)	\$0
61st thru 90th day	All but <del>\$198</del> <b>\$238</b>	<del>\$198—</del> <b>\$238</b>	\$0
91st day and after	a day	a day	
—While using 60 lifetime reserve days	All but <del>\$396</del> <b>\$476</b>	<del>\$396—</del> <b>\$476</b>	\$0
—Once lifetime reserve days are used:	a day	a day	
—Additional 365 days	\$0	100% of Medicare Eligible	\$0

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 <del>\$99</del> <b>\$119</b>	\$0	Up to <del>\$99</del> <b>\$119</b>
17		a day		a day
18	101st day and after	\$0	\$0	All costs
19	BLOOD			
20	First 3 pints	\$0	3 pints	\$0
21	Additional amounts	100%	\$0	\$0
22	HOSPICE CARE			
23	Available as long as your	All but very	\$0	Balance
24	doctor certifies you are	limited		
25	terminally ill and you	coinsurance		
26	elect to receive these	for outpatient		
27	services	drugs and		
28		inpatient		
29		respite care		

30 PLAN B

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

\*Once you have been billed ~~—\$100—~~ **\$124** of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First <del>\$100</del> <b>\$124</b> of Medicare			
Approved Amounts*	\$0	\$0	<del>\$100—</del> <b>\$124</b> (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0

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

10 PARTS A & B

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

25 PLAN C

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

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

5	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
6	HOSPITALIZATION*			
7	Semiprivate room and			
8	board, general nursing			
9	and miscellaneous			
10	services and supplies			
11	First 60 days	All but <del>\$792</del> <b>\$952</b>	<del>\$792</del> <b>\$952</b>	\$0
12			(Part A	
13			Deductible)	
14	61st thru 90th day	All but <del>\$198</del> <b>\$238</b>	<del>\$198</del> <b>\$238</b>	\$0
15		a day	a day	
16	91st day and after			
17	—While using 60			
18	lifetime reserve days	All but <del>\$396</del> <b>\$476</b>	<del>\$396</del> <b>\$476</b>	\$0
19		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 <del>\$99</del> <b>\$119</b>	Up to <del>\$99</del> <b>\$119</b>	\$0
13		a day	a day	
14	101st day and after	\$0	\$0	All costs
15	BLOOD			
16	First 3 pints	\$0	3 pints	\$0
17	Additional amounts	100%	\$0	\$0
18	HOSPICE CARE			
19	Available as long as your	All but very	\$0	Balance
20	doctor certifies you are	limited		
21	terminally ill and you	coinsurance		
22	elect to receive these	for outpatient		
23	services	drugs and		
24		inpatient		
25		respite care		

26 PLAN C

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

28 \*Once you have been billed ~~\$100~~ **\$124** of Medicare-Approved

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

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

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



1			Deductible)	
2	Remainder of Medicare			
3	Approved Amounts	80%	20%	\$0
4	CLINICAL LABORATORY			
5	SERVICES—			
6	<del>Blood tests</del> <b>TESTS</b> for			
7	diagnostic services	100%	\$0	\$0

8 PARTS A & B

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

23 OTHER BENEFITS—NOT COVERED BY MEDICARE

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

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

11 PLAN D

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

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

17	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
18	HOSPITALIZATION*			
19	Semiprivate room and			
20	board, general nursing			
21	and miscellaneous			
22	services and supplies			
23	First 60 days	All but <del>\$792</del> <b>\$952</b>	<del>\$792</del> <b>\$952</b>	\$0
24			(Part A	
25			Deductible)	
26	61st thru 90th day	All but <del>\$198</del> <b>\$238</b>	<del>\$198</del> <b>\$238</b>	\$0

1		a day	a day	
2	91st day and after			
3	-While using 60			
4	lifetime reserve days	All but <del>\$396</del> <b>\$476</b>	<del>\$396</del> <b>\$476</b>	\$0
5		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 <del>\$99</del> <b>\$119</b>	Up to <del>\$99</del> <b>\$119</b>	\$0
27		a day	a day	
28	101st day and after	\$0	\$0	All costs
29	BLOOD			
30	First 3 pints	\$0	3 pints	\$0

1	Additional amounts	100%	\$0	\$0
2	HOSPICE CARE			
3	Available as long as your	All but very	\$0	Balance
4	doctor certifies you are	limited		
5	terminally ill and you	coinsurance		
6	elect to receive these	for outpatient		
7	services	drugs and		
8		inpatient		
9		respite care		

10 PLAN D

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

12 \*Once you have been billed ~~—\$100—~~ **\$124** of Medicare-Approved  
 13 amounts for covered services (which are noted with an asterisk),  
 14 your Part B Deductible will have been met for the calendar year.

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

1	First <del>\$100</del> <b>\$124</b> of Medicare			
2	Approved Amounts*	\$0	\$0	<del>\$100</del> <b>\$124</b>
3				(Part B
4				Deductible)
5	Remainder of Medicare			
6	Approved Amounts	80%	20%	\$0
7	Part B Excess Charges			
8	(Above Medicare			
9	Approved Amounts)	\$0	\$0	All Costs
10	BLOOD			
11	First 3 pints	\$0	All Costs	\$0
12	Next <del>\$100</del> <b>\$124</b> of Medicare			
13	Approved Amounts*	\$0	\$0	<del>\$100</del> <b>\$124</b>
14				(Part B
15				Deductible)
16	Remainder of Medicare			
17	Approved Amounts	80%	20%	\$0
18	CLINICAL LABORATORY			
19	SERVICES—			
20	<del>Blood tests</del> <b>TESTS</b> for			
21	diagnostic services	100%	\$0	\$0
22	PARTS A & B			
23	HOME HEALTH CARE			
24	Medicare Approved			
25	Services			
26	—Medically necessary			
27	skilled care services			
28	and medical supplies	100%	\$0	\$0
29	—Durable medical			

1	equipment			
2	First <del>\$100</del> <b>\$124</b> of Medicare			
3	Approved Amounts*	\$0	\$0	<del>\$100</del> <b>\$124</b>
4				(Part B
5				Deductible)
6	Remainder of Medicare			
7	Approved Amounts	80%	20%	\$0
8	AT-HOME RECOVERY			
9	SERVICES—			
10	Not covered by Medicare			
11	Home care certified by			
12	your doctor, for personal			
13	care during recovery from			
14	an injury or sickness for			
15	which Medicare approved a			
16	Home Care Treatment Plan			
17	—Benefit for each visit	\$0	Actual	
18			Charges to	
19			\$40 a visit	Balance
20	—Number of visits			
21	covered (must be			
22	received within 8			
23	weeks of last			
24	Medicare Approved			
25	visit)	\$0	Up to the	
26			number of	
27			Medicare	
28			Approved	
29			visits, not	
30			to exceed 7	

1			each week	
2	-Calendar year maximum	\$0	\$1,600	

3 OTHER BENEFITS—NOT COVERED BY MEDICARE

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

19 PLAN E

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

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

25	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
26	HOSPITALIZATION*			

1	Semiprivate room and			
2	board, general nursing			
3	and miscellaneous			
4	services and supplies			
5	First 60 days	All but <del>\$792</del> <b>\$952</b>	<del>\$792</del> <b>\$952</b>	\$0
6			(Part A	
7			Deductible)	
8	61st thru 90th day	All but <del>\$198</del> <b>\$238</b>	<del>\$198</del> <b>\$238</b>	\$0
9		a day	a day	
10	91st day and after			
11	-While using 60			
12	lifetime reserve days	All but <del>\$396</del> <b>\$476</b>	<del>\$396</del> <b>\$476</b>	\$0
13		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		
4		amounts	\$0	\$0
5	21st thru 100th day	All but <del>\$99</del> <b>\$119</b>	Up to <del>\$99</del> <b>\$119</b>	\$0
6		a day	a day	
7	101st day and after	\$0	\$0	All costs
8	BLOOD			
9	First 3 pints	\$0	3 pints	\$0
10	Additional amounts	100%	\$0	\$0
11	HOSPICE CARE			
12	Available as long as your	All but very	\$0	Balance
13	doctor certifies you are	limited		
14	terminally ill and you	coinsurance		
15	elect to receive these	for outpatient		
16	services	drugs and		
17		inpatient		
18		respite care		

19 PLAN E

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

21 \*Once you have been billed ~~—\$100—~~ **\$124** 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	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
25	MEDICAL EXPENSES—			
26	In or out of the hospital			
27	and outpatient hospital			

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

1 PARTS A & B

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

16 OTHER BENEFITS—NOT COVERED BY MEDICARE

17	FOREIGN TRAVEL—			
18	Not covered by Medicare			
19	Medically necessary			
20	emergency care services			
21	beginning during the			
22	first 60 days of each			
23	trip outside the USA			
24	First \$250 each			
25	calendar year	\$0	\$0	\$250
26	Remainder of Charges	\$0	80% to a	20% and
27			lifetime	amounts
28			maximum	over the

1			benefit	\$50,000
2			of \$50,000	lifetime
3				maximum
4	PREVENTIVE MEDICAL CARE			
5	BENEFIT—			
6	Not covered by Medicare			
7	Annual physical and			
8	preventive tests and			
9	services <del>such as: fecal</del>			
10	<del>occult blood test,</del>			
11	<del>digital rectal exam,</del>			
12	<del>mammogram, hearing</del>			
13	<del>screening, dipstick</del>			
14	<del>urinalysis, diabetes</del>			
15	<del>screening, thyroid</del>			
16	<del>function test, influenza</del>			
17	<del>shot, tetanus and</del>			
18	<del>diphtheria booster and</del>			
19	education, administered			
20	or ordered by your			
21	doctor when not covered			
22	by Medicare			
23	First \$120 each			
24	calendar year	\$0	\$120	\$0
25	Additional charges	\$0	\$0	All Costs

26 PLAN F OR HIGH DEDUCTIBLE PLAN F

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

28 \*A benefit period begins on the first day you receive service  
 29 as an inpatient in a hospital and ends after you have been out of

1 the hospital and have not received skilled care in any other  
 2 facility for 60 days in a row.  
 3 \*\*This high deductible plan pays the same ~~or offers the same~~  
 4 benefits as plan F after you have paid a calendar year ~~—(\$1,580)~~  
 5 **(\$1,790)** deductible. Benefits from the high deductible plan F  
 6 will not begin until out-of-pocket expenses are ~~—\$1,580~~ **\$1,790**.  
 7 Out-of-pocket expenses for this deductible are expenses that  
 8 would ordinarily be paid by the policy. This includes medicare  
 9 deductibles for part A and part B, but does not include the  
 10 plan's separate foreign travel emergency deductible.

11	SERVICES	MEDICARE	AFTER YOU	IN ADDITION
12		PAYS	PAY <del>\$1,580</del>	TO <del>\$1,580</del>
13			<b>\$1,790</b>	<b>\$1,790</b>
14			DEDUCTIBLE**, PLAN PAYS	DEDUCTIBLE**, 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 <del>\$792</del> <b>\$952</b>	<del>\$792</del> <b>\$952</b>	\$0
21			(Part A	
22			Deductible)	
23	61st thru 90th day	All but <del>\$198</del> <b>\$238</b>	<del>\$198</del> <b>\$238</b>	\$0
24		a day	a day	
25	91st day and after			
26	—While using 60			

1	lifetime reserve days	All but <del>\$396</del> <b>\$476</b>	<del>\$396</del> <b>\$476</b>	\$0
2		a day	a day	
3	-Once lifetime reserve			
4	days are used:			
5	-Additional 365 days	\$0	100% of	\$0
6			Medicare	
7			Eligible	
8			Expenses	
9	-Beyond the			
10	Additional 365 days	\$0	\$0	All Costs
11	SKILLED NURSING FACILITY			
12	CARE*			
13	You must meet Medicare's			
14	requirements, including			
15	having been in a			
16	hospital for at least			
17	3 days and entered a			
18	Medicare-approved			
19	facility within 30 days			
20	after leaving the			
21	hospital			
22	First 20 days	All approved		
23		amounts	\$0	\$0
24	21st thru 100th day	All but <del>\$99</del> <b>\$119</b>	Up to <del>\$99</del> <b>\$119</b>	\$0
25		a day	a day	
26	101st day and after	\$0	\$0	All costs
27	BLOOD			
28	First 3 pints	\$0	3 pints	\$0
29	Additional amounts	100%	\$0	\$0
30	HOSPICE CARE			

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

## PLAN F

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

11 \*Once you have been billed ~~—\$100—~~ **\$124** of Medicare-Approved  
 12 amounts for covered services (which are noted with an asterisk),  
 13 your Part B Deductible will have been met for the calendar year.  
 14 \*\*This high deductible plan pays the same ~~—or offers the same~~  
 15 benefits as plan F after you have paid a calendar year ~~—(\$1,580)~~  
 16 **(\$1,790)** deductible. Benefits from the high deductible plan F  
 17 will not begin until out-of-pocket expenses are ~~—\$1,580—~~ **\$1,790**.  
 18 Out-of-pocket expenses for this deductible are expenses that  
 19 would ordinarily be paid by the policy. This includes medicare  
 20 deductibles for part A and part B, but does not include the  
 21 plan's separate foreign travel emergency deductible.

22	SERVICES	MEDICARE	AFTER YOU	IN ADDITION
23		PAYS	PAY <del>\$1,580</del> <b>\$1,790</b>	TO <del>\$1,580</del> <b>\$1,790</b>
24			DEDUCTIBLE**,	DEDUCTIBLE**,
25			PLAN PAYS	YOU PAY
26	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 <del>\$100</del> <b>\$124</b> of Medicare			
13	Approved Amounts*	\$0	<del>\$100</del> <b>\$124</b>	\$0
14			(Part B	
15			Deductible)	
16	Remainder of Medicare			
17	Approved Amounts	80%	20%	\$0
18	Part B Excess Charges			
19	(Above Medicare			
20	Approved Amounts)	\$0	100%	\$0
21	BLOOD			
22	First 3 pints	\$0	All Costs	\$0
23	Next <del>\$100</del> <b>\$124</b> of Medicare			
24	Approved Amounts*	\$0	<del>\$100</del> <b>\$124</b>	\$0
25			(Part B	
26			Deductible)	
27	Remainder of Medicare			
28	Approved Amounts	80%	20%	\$0
29	CLINICAL LABORATORY			
30	SERVICES—			



1	<del>Blood tests</del> <b>TESTS</b> for			
2	diagnostic services	100%	\$0	\$0

3 PARTS A & B

4	HOME HEALTH CARE			
5	Medicare Approved			
6	Services			
7	-Medically necessary			
8	skilled care services			
9	and medical supplies	100%	\$0	\$0
10	-Durable medical			
11	equipment			
12	First <del>\$100</del> <b>\$124</b> of			
13	Medicare			
14	Approved Amounts*	\$0	<del>\$100</del> <b>\$124</b>	\$0
15			(Part B	
16	Remainder of Medicare		Deductible)	
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			
27	calendar year	\$0	\$0	\$250
28	Remainder of charges	\$0	80% to a	20% and

1		lifetime	amounts
2		maximum	over the
3		benefit	\$50,000
4		of \$50,000	lifetime
5			maximum

6 PLAN G

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

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

12	SERVICES	MEDICARE PAYS	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 <del>\$792</del> <b>\$952</b>	<del>\$792—</del> <b>\$952</b> (Part A Deductible)	\$0
19				
20				
21	61st thru 90th day	All but <del>\$198</del> <b>\$238</b>	<del>\$198—</del> <b>\$238</b>	\$0
22		a day	a day	
23	91st day and after			
24	—While using 60			
25	lifetime reserve days	All but <del>\$396</del> <b>\$476</b>	<del>\$396—</del> <b>\$476</b>	\$0

1		a day	a day	
2	—Once lifetime reserve			
3	days are used:			
4	—Additional 365 days	\$0	100% of	\$0
5			Medicare	
6			Eligible	
7			Expenses	
8	—Beyond the			
9	Additional 365 days	\$0	\$0	All Costs
10	SKILLED NURSING FACILITY			
11	CARE*			
12	You must meet Medicare's			
13	requirements, including			
14	having been in a hospital			
15	for at least 3 days and			
16	entered a Medicare-			
17	approved facility within			
18	30 days after leaving the			
19	hospital			
20	First 20 days	All approved		
21		amounts	\$0	\$0
22	21st thru 100th day	All but <del>\$99</del> <b>\$119</b>	Up to <del>\$99</del> <b>\$119</b>	\$0
23		a day	a day	
24	101st day and after	\$0	\$0	All costs
25	BLOOD			
26	First 3 pints	\$0	3 pints	\$0
27	Additional amounts	100%	\$0	\$0
28	HOSPICE CARE			
29	Available as long as your	All but very	\$0	Balance
30	doctor certifies you are	limited		

1	terminally ill and you	coinsurance		
2	elect to receive these	for outpatient		
3	services	drugs and		
4		inpatient		
5		respite care		

6 PLAN G

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

8 \*Once you have been billed ~~—\$100—~~ **\$124** of Medicare-Approved  
 9 amounts for covered services (which are noted with an asterisk),  
 10 your Part B Deductible will have been met for the calendar year.

11	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
12	MEDICAL EXPENSES—			
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 <del>\$100</del> <b>\$124</b> of Medicare			
25	Approved Amounts*	\$0	\$0	<del>\$100</del> <b>\$124</b>
26				(Part B
27				Deductible)

1	Remainder of Medicare			
2	Approved Amounts	80%	20%	\$0
3	Part B Excess Charges			
4	(Above Medicare			
5	Approved Amounts)	\$0	80%	20%
6	BLOOD			
7	First 3 pints	\$0	All Costs	\$0
8	Next <del>\$100</del> <b>\$124</b> of Medicare			
9	Approved Amounts*	\$0	\$0	<del>\$100</del> <b>\$124</b>
10				(Part B
11				Deductible)
12	Remainder of Medicare			
13	Approved Amounts	80%	20%	\$0
14	CLINICAL LABORATORY			
15	SERVICES—			
16	<del>Blood tests</del> <b>TESTS</b> for			
17	diagnostic services	100%	\$0	\$0
18	PARTS A & B			
19	HOME HEALTH CARE			
20	Medicare Approved			
21	Services			
22	—Medically necessary			
23	skilled care services			
24	and medical supplies	100%	\$0	\$0
25	—Durable medical			
26	equipment			
27	First <del>\$100</del> <b>\$124</b> of Medicare			
28	Approved Amounts*	\$0	\$0	<del>\$100</del> <b>\$124</b>
29				(Part B

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

16

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

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

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

1	First 60 days	All but <del>\$792</del> <b>\$952</b>	<del>\$792</del> <b>\$952</b>	\$0
2			(Part A	
3			Deductible)	
4	61st thru 90th day	All but <del>\$198</del> <b>\$238</b>	<del>\$198</del> <b>\$238</b>	\$0
5		a day	a day	
6	91st day and after			
7	-While using 60			
8	lifetime reserve days	All but <del>\$396</del> <b>\$476</b>	<del>\$396</del> <b>\$476</b>	\$0
9		a day	a day	
10	-Once lifetime reserve			
11	days are used:			
12	-Additional 365 days	\$0	100% of	\$0
13			Medicare	
14			Eligible	
15			Expenses	
16	-Beyond the			
17	Additional 365 days	\$0	\$0	All Costs
18	SKILLED NURSING FACILITY			
19	CARE*			
20	You must meet Medicare's			
21	requirements, including			
22	having been in a hospital			
23	for at least 3 days and			
24	entered a Medicare-			
25	approved facility within			
26	30 days after leaving the			
27	hospital			
28	First 20 days	All approved		
29		amounts	\$0	\$0



1	21st thru 100th day	All but <del>\$99</del> <b>\$119</b>	Up to <del>\$99</del> <b>\$119</b>	\$0
2		a day	a day	
3	101st day and after	\$0	\$0	All costs
4	BLOOD			
5	First 3 pints	\$0	3 pints	\$0
6	Additional amounts	100%	\$0	\$0
7	HOSPICE CARE			
8	Available as long as your	All but very	\$0	Balance
9	doctor certifies you are	limited		
10	terminally ill and you	coinsurance		
11	elect to receive these	for outpatient		
12	services	drugs and		
13		inpatient		
14		respite care		

15 PLAN H

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

17 \*Once you have been billed ~~—\$100—~~ **\$124** of Medicare-Approved  
 18 amounts for covered services (which are noted with an asterisk),  
 19 your Part B Deductible will have been met for the calendar year.

20	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
21	MEDICAL EXPENSES—			
22	In or out of the hospital			
23	and outpatient hospital			
24	treatment, such as			
25	Physician's services,			
26	inpatient and outpatient			
27	medical and surgical			

1	services and supplies,			
2	physical and speech			
3	therapy, diagnostic			
4	tests, durable medical			
5	equipment,			
6	First <del>\$100</del> <b>\$124</b> of Medicare			
7	Approved Amounts*	\$0	\$0	<del>\$100</del> <b>\$124</b>
8				(Part B
9				Deductible)
10	Remainder of Medicare			
11	Approved Amounts	80%	20%	\$0
12	Part B Excess Charges			
13	(Above Medicare			
14	Approved Amounts)	\$0	\$0	All Costs
15	BLOOD			
16	First 3 pints	\$0	All Costs	\$0
17	Next <del>\$100</del> <b>\$124</b> of Medicare			
18	Approved Amounts*	\$0	\$0	<del>\$100</del> <b>\$124</b>
19				(Part B
20				Deductible)
21	Remainder of Medicare			
22	Approved Amounts	80%	20%	\$0
23	CLINICAL LABORATORY			
24	SERVICES—			
25	<del>Blood tests</del> <b>TESTS</b> for			
26	diagnostic services	100%	\$0	\$0
27	PARTS A & B			
28	HOME HEALTH CARE			
29	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 <del>\$100</del> <b>\$124</b> of			
8	Medicare			
9	Approved Amounts*	\$0	\$0	<del>\$100</del> <b>\$124</b>
10				(Part B
11	Remainder of Medicare			Deductible)
12	Approved Amounts	80%	20%	\$0

13                   OTHER BENEFITS–NOT COVERED BY MEDICARE

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

1	<del>SCRIPTION DRUGS</del>			
2	<del>Not covered by Medicare</del>			
3	<del>First \$250 each</del>			
4	<del>calendar year</del>	<del>\$0</del>	<del>\$0</del>	<del>\$250</del>
5	<del>Next \$2,500 each</del>			
6	<del>calendar year</del>	<del>\$0</del>	<del>50% \$1,250</del>	<del>50%</del>
7			<del>calendar</del>	
8			<del>year</del>	
9			<del>maximum</del>	
10			<del>benefit</del>	
11	<del>Over \$2,500 each</del>			
12	<del>calendar year</del>	<del>\$0</del>	<del>\$0</del>	<del>All Costs</del>

13 PLAN I

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

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

16 as an inpatient in a hospital and ends after you have been out of

17 the hospital and have not received skilled care in any other

18 facility for 60 days in a row.

19	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
20	HOSPITALIZATION*			
21	Semiprivate room and			
22	board, general nursing			
23	and miscellaneous			
24	services and supplies			
25	First 60 days	All but <del>\$792</del> <b>\$952</b>	<del>\$792</del> <b>\$952</b>	\$0
26			(Part A	

1			Deductible)	
2	61st thru 90th day	All but <del>\$198</del> <b>\$238</b>	<del>\$198</del> <b>\$238</b>	\$0
3		a day	a day	
4	91st day and after			
5	-While using 60			
6	lifetime reserve days	All but <del>\$396</del> <b>\$476</b>	<del>\$396</del> <b>\$476</b>	\$0
7		a day	a day	
8	-Once lifetime reserve			
9	days are used:			
10	-Additional 365 days	\$0	100% of	\$0
11			Medicare	
12			Eligible	
13			Expenses	
14	-Beyond the			
15	Additional 365 days	\$0	\$0	All Costs
16	SKILLED NURSING FACILITY			
17	CARE*			
18	You must meet Medicare's			
19	requirements, including			
20	having been in a hospital			
21	for at least 3 days and			
22	entered a Medicare-			
23	approved facility within			
24	30 days after leaving the			
25	hospital			
26	First 20 days	All approved		
27		amounts	\$0	\$0
28	21st thru 100th day	All but <del>\$99</del> <b>\$119</b>	Up to <del>\$99</del> <b>\$119</b>	\$0
29		a day	a day	

1	101st day and after	\$0	\$0	All costs
2	BLOOD			
3	First 3 pints	\$0	3 pints	\$0
4	Additional amounts	100%	\$0	\$0
5	HOSPICE CARE			
6	Available as long as your	All but very	\$0	Balance
7	doctor certifies you are	limited		
8	terminally ill and you	coinsurance		
9	elect to receive these	for outpatient		
10	services	drugs and		
11		inpatient		
12		respite care		

13 PLAN I

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

15 \*Once you have been billed ~~—\$100—~~ **\$124** of Medicare-Approved  
 16 amounts for covered services (which are noted with an asterisk),  
 17 your Part B Deductible will have been met for the calendar year.

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

1	tests, durable medical			
2	equipment,			
3	First <del>\$100</del> <b>\$124</b> of			
3	Medicare			
4	Approved Amounts*	\$0	\$0	<del>\$100</del> <b>\$124</b>
5				(Part B
6				Deductible)
7	Remainder of Medicare			
8	Approved Amounts	80%	20%	\$0
9	Part B Excess Charges			
10	(Above Medicare			
11	Approved Amounts)	\$0	100%	\$0
12	BLOOD			
13	First 3 pints	\$0	All Costs	\$0
14	Next <del>\$100</del> <b>\$124</b> of			
14	Medicare			
15	Approved Amounts*	\$0	\$0	<del>\$100</del> <b>\$124</b>
16				(Part B
17				Deductible)
18	Remainder of Medicare			
19	Approved Amounts	80%	20%	\$0
20	CLINICAL LABORATORY			
21	SERVICES—			
22	<del>Blood tests</del> <b>TESTS</b> for			
23	diagnostic services	100%	\$0	\$0
24	PARTS A & B			
25	HOME HEALTH CARE			
26	Medicare Approved			
27	Services			
28	—Medically necessary			
29	skilled care services			

1	and medical supplies	100%	\$0	\$0
2	-Durable medical			
3	equipment			
4	First <del>\$100</del> <b>\$124</b> of Medicare			
5	Approved Amounts*	\$0	\$0	<del>\$100</del> <b>\$124</b>
6				(Part B
7				Deductible)
8	Remainder of Medicare			
9	Approved Amounts	80%	20%	\$0
10	AT-HOME RECOVERY			
11	SERVICES-			
12	Not covered by Medicare			
13	Home care certified by			
14	your doctor, for personal			
15	care during recovery from			
16	an injury or sickness for			
17	which Medicare approved a			
18	Home Care Treatment Plan			
19	-Benefit for each visit	\$0	Actual	
20			Charges to	
21			\$40 a visit	Balance
22	-Number of visits			
23	covered (must be			
24	received within 8			
25	weeks of last			
26	Medicare Approved			
27	visit)	\$0	Up to the	
28			number of	
29			Medicare	
30			Approved	
31			visits, not	



1			to exceed 7	
2			each week	
3	-Calendar year maximum	\$0	\$1,600	
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	<del>BASIC OUTPATIENT PRE-</del>			
21	<del>SCRIPTION DRUGS—</del>			
22	<del>Not covered by Medicare</del>			
23	<del>—First \$250 each</del>			
24	<del>—calendar year</del>	<del>\$0</del>	<del>\$0</del>	<del>\$250</del>
25	<del>—Next \$2,500 each</del>			
26	<del>—calendar year</del>	<del>\$0</del>	<del>50%—\$1,250</del>	<del>50%</del>
27			<del>calendar</del>	
28			<del>year</del>	
29			<del>maximum</del>	
30			<del>benefit</del>	

1	<del>Over \$2,500 each</del>			
2	<del>calendar year</del>	<del>\$0</del>	<del>\$0</del>	<del>All Costs</del>

3 PLAN J OR HIGH DEDUCTIBLE PLAN J

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

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

9 \*\*This high deductible plan pays the same ~~or offers the same~~  
10 benefits as plan J after you have paid a calendar year ~~—(\$1,580)~~  
11 **(\$1,790)** deductible. Benefits from the high deductible plan J  
12 will not begin until out-of-pocket expenses are ~~—\$1,580~~ **\$1,790**.  
13 Out-of-pocket expenses for this deductible are expenses that  
14 would ordinarily be paid by the policy. This includes medicare  
15 deductibles for part A and part B, but does not include the  
16 plan's **OUTPATIENT PRESCRIPTION DRUG DEDUCTIBLE OR** separate  
17 foreign travel emergency deductible.

18	SERVICES	MEDICARE PAYS	AFTER YOU	IN ADDITION
19			PAY <del>\$1,580</del> <b>\$1,790</b>	TO <del>\$1,580</del> <b>\$1,790</b>
20			DEDUCTIBLE**,	DEDUCTIBLE**,
21			PLAN PAYS	YOU PAY
22	HOSPITALIZATION*			
23	Semiprivate room and			
24	board, general nursing			

1	and miscellaneous			
2	services and supplies			
3	First 60 days	All but <del>\$792</del> <b>\$952</b>	<del>\$792—</del> <b>\$952</b>	\$0
4			(Part A	
5			Deductible)	
6	61st thru 90th day	All but <del>\$198</del> <b>\$238</b>	<del>\$198—</del> <b>\$238</b>	\$0
7		a day	a day	
8	91st day and after			
9	—While using 60			
10	lifetime reserve days	All but <del>\$396</del> <b>\$476</b>	<del>\$396—</del> <b>\$476</b>	\$0
11		a day	a day	
12	—Once lifetime reserve			
13	days are used:			
14	—Additional 365 days	\$0	100% of	\$0***
15			Medicare	
16			Eligible	
17			Expenses	
18	—Beyond the			
19	Additional 365 days	\$0	\$0	All Costs
20	SKILLED NURSING FACILITY			
21	CARE*			
22	You must meet Medicare's			
23	requirements, including			
24	having been in a hospital			
25	for at least 3 days and			
26	entered a Medicare-			
27	approved facility within			
28	30 days after leaving the			
29	hospital			

1	First 20 days	All approved		
2		amounts	\$0	\$0
3	21st thru 100th day	All but <del>\$99</del> <b>\$119</b>	Up to <del>\$99</del> <b>\$119</b>	\$0
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	<del>HOSPICE CARE</del>			
10	<del>Available as long as your</del>	<del>All but very</del>	<del>\$0</del>	<del>Balance</del>
11	<del>doctor certifies you are</del>	<del>limited</del>		
12	<del>terminally ill and you</del>	<del>coinsurance</del>		
13	<del>elect to receive these</del>	<del>for outpatient</del>		
14	<del>services</del>	<del>drugs and</del>		
15		<del>inpatient</del>		
16		<del>respite care</del>		

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

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

26 **\*Once you have been billed ~~-\$100-~~ \$124 of Medicare-Approved**  
 27 **amounts for covered services (which are noted with an asterisk),**

1 your Part B Deductible will have been met for the calendar year.  
 2 \*\*This high deductible plan pays the same or offers the same  
 3 benefits as plan J after you have paid a calendar year ~~—(\$1,580)~~  
 4 **(\$1,790)** deductible. Benefits from the high deductible plan J  
 5 will not begin until out-of-pocket expenses are ~~—\$1,580~~ **\$1,790**.  
 6 Out-of-pocket expenses for this deductible are expenses that  
 7 would ordinarily be paid by the policy. This includes medicare  
 8 deductibles for part A and part B, but does not include the  
 9 plan's separate **OUTPATIENT PRESCRIPTION DRUG DEDUCTIBLE OR**  
 10 foreign travel emergency deductible.

11	SERVICES	MEDICARE PAYS	AFTER YOU	IN ADDITION
12			PAY <del>\$1,580</del> <b>\$1,790</b>	TO <del>\$1,580</del> <b>\$1,790</b>
13			DEDUCTIBLE**,	DEDUCTIBLE**,
14			PLAN PAYS	YOU PAY
15	<b>HOSPICE CARE</b>			
16	<b>AVAILABLE AS LONG AS YOUR</b>	<b>ALL BUT VERY</b>	<b>\$0</b>	<b>BALANCE</b>
17	<b>DOCTOR CERTIFIES YOU ARE</b>	<b>LIMITED</b>		
18	<b>TERMINALLY ILL AND YOU</b>	<b>COINSURANCE</b>		
19	<b>ELECT TO RECEIVE THESE</b>	<b>FOR OUTPATIENT</b>		
20	<b>SERVICES</b>	<b>DRUGS AND</b>		
21		<b>INPATIENT</b>		
22		<b>RESPITE CARE</b>		
23	<b>MEDICAL EXPENSES—</b>			
24	In or out of the hospital			
25	and outpatient hospital			

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

1 PARTS A & B

2	HOME HEALTH CARE			
3	Medicare Approved			
4	Services			
5	-Medically necessary			
6	skilled care services			
7	and medical supplies	100%	\$0	\$0
8	-Durable medical			
9	equipment			
10	First <del>\$100</del> <b>\$124</b> of			
	Medicare			
11	Approved Amounts*	\$0	<del>\$100</del> <b>\$124</b>	\$0
12			(Part B	
13			Deductible)	
14	Remainder of Medicare			
15	Approved Amounts	80%	20%	\$0
16	AT-HOME RECOVERY			
17	SERVICES-			
18	Not covered by Medicare			
19	Home care certified by			
20	your doctor, for personal			
21	care beginning during			
22	recovery from an injury			
23	or sickness for which			
24	Medicare approved a			
25	Home Care Treatment Plan			
26	-Benefit for each visit	\$0	Actual	
27			Charges to	
28			\$40 a visit	Balance
29	-Number of visits			

1	covered (must be			
2	received within 8			
3	weeks of last visit)			
4	Medicare Approved	\$0	Up to the	
5			number of	
6			Medicare	
7			Approved	
8			visits, not	
9			to exceed 7	
10			each week	
11	-Calendar year maximum	\$0	\$1,600	

12 OTHER BENEFITS—NOT COVERED BY MEDICARE

13	FOREIGN TRAVEL—			
14	Not covered by Medicare			
15	Medically necessary			
16	emergency care services			
17	beginning during the			
18	first 60 days of each			
19	trip outside the USA			
20	First \$250 each			
21	calendar year	\$0	\$0	\$250
22	Remainder of Charges	\$0	80% to a	20% and
23			lifetime	amounts
24			maximum	over the
25			benefit	\$50,000
26			of \$50,000	lifetime
27				maximum
28	<del>EXTENDED OUTPATIENT PRE-</del>			
29	<del>SCRIPTION DRUGS—</del>			
30	<del>Not covered by Medicare</del>			



1	<del>First \$250 each</del>			
2	<del>calendar year</del>	\$0	\$0	\$250
3	<del>Next \$6,000 each</del>			
4	<del>calendar year</del>	\$0	50% <del>\$3,000</del>	50%
5			calendar	
6			year	
7			maximum	
8			benefit	
9	<del>Over \$6,000 each</del>			
10	<del>calendar year</del>	\$0	\$0	<del>All Costs</del>
11	PREVENTIVE MEDICAL CARE			
12	BENEFIT-			
13	Not covered by Medicare			
14	Annual physical and			
15	preventive tests and			
16	services <del>such as: fecal</del>			
17	<del>occult blood test,</del>			
18	<del>digital rectal exam,</del>			
19	<del>mammogram, hearing</del>			
20	<del>screening, dipstick</del>			
21	<del>urinalysis, diabetes</del>			
22	<del>screening, thyroid</del>			
23	<del>function test, influenza</del>			
24	<del>shot, tetanus and</del>			
25	<del>diphtheria booster and</del>			
26	education, administered			
27	or ordered by your doctor			
28	when not covered by			
29	Medicare			
30	First \$120 each			
31	calendar year	\$0	\$120	\$0

1	Additional charges	\$0	\$0	All costs
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2 PLAN K

3 \* YOU WILL PAY HALF THE COST-SHARING OF SOME COVERED  
 4 SERVICES UNTIL YOU REACH THE ANNUAL OUT-OF-POCKET LIMIT OF \$4,000  
 5 EACH CALENDAR YEAR. THE AMOUNTS THAT COUNT TOWARD YOUR ANNUAL  
 6 LIMIT ARE NOTED WITH DIAMONDS (♦) IN THE CHART BELOW. ONCE YOU  
 7 REACH THE ANNUAL LIMIT, THE PLAN PAYS 100% OF YOUR MEDICARE  
 8 COPAYMENT AND COINSURANCE FOR THE REST OF THE CALENDAR YEAR.  
 9 HOWEVER, THIS LIMIT DOES NOT INCLUDE CHARGES FROM YOUR PROVIDER  
 10 THAT EXCEED MEDICARE-APPROVED AMOUNTS (THESE ARE CALLED "EXCESS  
 11 CHARGES") AND YOU WILL BE RESPONSIBLE FOR PAYING THIS DIFFERENCE  
 12 IN THE AMOUNT CHARGED BY YOUR PROVIDER AND THE AMOUNT PAID BY  
 13 MEDICARE FOR THE ITEM OR SERVICE.

14 PLAN K

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

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

20	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
21	HOSPITALIZATION**			
22	SEMIPRIVATE ROOM AND			
23	BOARD, GENERAL NURSING			
24	AND MISCELLANEOUS			

1	SERVICES AND SUPPLIES			
2	FIRST 60 DAYS	ALL BUT \$952	\$476 (50%	\$476 (50% OF
3			OF PART A	PART A
4			DEDUCTI-	DEDUCTIBLE)◆
5			BLE)	
6				
7	61ST THRU 90TH DAY	ALL BUT \$238	\$238	\$0
8		A DAY	A DAY	
9	91ST DAY AND AFTER:			
10	—WHILE USING 60			
11	LIFETIME RESERVE DAYS	ALL BUT \$476	\$476	\$0
12		A DAY	A DAY	
13	—ONCE LIFETIME RESERVE			
14	DAYS ARE USED:			
15	—ADDITIONAL 365 DAYS	\$0	100% OF	\$0***
16			MEDICARE	
17			ELIGIBLE	
18			EXPENSES	
19	—BEYOND THE			
20	ADDITIONAL 365 DAYS	\$0	\$0	ALL COSTS
21	SKILLED NURSING FACILITY			
22	CARE**			
23	YOU MUST MEET MEDICARE'S			
24	REQUIREMENTS, INCLUDING			
25	HAVING BEEN IN A HOSPITAL			
26	FOR AT LEAST 3 DAYS AND			
27	ENTERED A MEDICARE-			
28	APPROVED FACILITY WITHIN			
29	30 DAYS AFTER LEAVING THE			
30	HOSPITAL			
31	FIRST 20 DAYS	ALL APPROVED		

1		AMOUNTS	\$0	\$0
2	21ST THRU 100TH DAY	ALL BUT	UP TO	UP TO
3		\$119 A	\$59.50	\$59.50
4		DAY	A DAY	A DAY♦
5	101ST DAY AND AFTER	\$0	\$0	ALL COSTS
6	BLOOD			
7	FIRST 3 PINTS	\$0	50%	50%♦
8	ADDITIONAL AMOUNTS	100%	\$0	\$0
9	HOSPICE CARE			
10	AVAILABLE AS LONG AS YOUR	GENERALLY,	50% OF	50% OF
11	DOCTOR CERTIFIES YOU ARE	MOST MEDICARE	COINSUR-	COINSUR-
12	TERMINALLY ILL AND YOU	ELIGIBLE	ANCE OR	ANCE OR
13	ELECT TO RECEIVE THESE	EXPENSES FOR	COPAYMENTS	COPAYMENTS♦
14	SERVICES	OUTPATIENT		
15		DRUGS AND		
16		INPATIENT		
17		RESPIRE CARE		

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

25 PLAN K  
 26 MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

27 \*\*\*\*ONCE YOU HAVE BEEN BILLED \$124 OF MEDICARE-APPROVED

1 AMOUNTS FOR COVERED SERVICES (WHICH ARE NOTED WITH AN ASTERISK),  
 2 YOUR PART B DEDUCTIBLE WILL HAVE BEEN MET FOR THE CALENDAR YEAR.

3	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
4	MEDICAL EXPENSES—			
5	IN OR OUT OF THE HOSPITAL			
6	AND OUTPATIENT HOSPITAL			
7	TREATMENT, SUCH AS			
8	PHYSICIAN'S SERVICES,			
9	INPATIENT AND OUTPATIENT			
10	MEDICAL AND SURGICAL			
11	SERVICES AND SUPPLIES,			
12	PHYSICAL AND SPEECH			
13	THERAPY, DIAGNOSTIC			
14	TESTS, DURABLE MEDICAL			
15	EQUIPMENT,			
16	FIRST \$124 OF MEDICARE			
17	APPROVED AMOUNTS****	\$0	\$0	\$124 (PART B
18				DEDUCTIBLE)
19				****♦
20	PREVENTIVE BENEFITS FOR	GENERALLY 75%	REMAINDER	ALL COSTS
21	MEDICARE COVERED	OR MORE OF	OF MEDI-	ABOVE MEDI-
22	SERVICES	MEDICARE AP-	CARE	CARE
23		PROVED AMOUNTS	APPROVED	APPROVED
24			AMOUNTS	AMOUNTS
25	REMAINDER OF MEDICARE	GENERALLY 80%	GENERALLY	GENERALLY
26	APPROVED AMOUNTS		10%	10%♦
27	PART B EXCESS CHARGES	\$0	\$0	ALL COSTS
28	(ABOVE MEDICARE			(AND THEY DO
29	APPROVED AMOUNTS)			NOT COUNT

1				TOWARD
2				ANNUAL OUT-
3				OF-POCKET
4				LIMIT OF
5				\$4,000)*
6	BLOOD			
7	FIRST 3 PINTS	\$0	50%	50%♦
8	NEXT \$124 OF MEDICARE			
9	APPROVED AMOUNTS****	\$0	\$0	\$124 (PART B
10				DEDUCTIBLE)
11				****♦
12	REMAINDER OF MEDICARE	GENERALLY 80%	GENERALLY	GENERALLY
13	APPROVED AMOUNTS		10%	10%♦
14	CLINICAL LABORATORY			
15	SERVICES-TESTS FOR			
16	DIAGNOSTIC SERVICES	100%	\$0	\$0

17 \* THIS PLAN LIMITS YOUR ANNUAL OUT-OF-POCKET PAYMENTS FOR  
 18 MEDICARE-APPROVED AMOUNTS TO \$4,000 PER YEAR. HOWEVER, THIS LIMIT  
 19 DOES NOT INCLUDE CHARGES FROM YOUR PROVIDER THAT EXCEED MEDICARE-  
 20 APPROVED AMOUNTS (THESE ARE CALLED "EXCESS CHARGES") AND YOU WILL  
 21 BE RESPONSIBLE FOR PAYING THIS DIFFERENCE IN THE AMOUNT CHARGED  
 22 BY YOUR PROVIDER AND THE AMOUNT PAID BY MEDICARE FOR THE ITEM OR  
 23 SERVICE.

24 PARTS A & B

25	HOME HEALTH CARE			
26	MEDICARE APPROVED			
27	SERVICES			

1	—MEDICALLY NECESSARY			
2	SKILLED CARE SERVICES			
3	AND MEDICAL SUPPLIES	100%	\$0	\$0
4	—DURABLE MEDICAL			
5	EQUIPMENT			
6	FIRST \$124 OF MEDICARE			
7	APPROVED AMOUNTS*****	\$0	\$0	\$124 (PART B
8				DEDUCTIBLE)♦
9	REMAINDER OF MEDICARE			
10	APPROVED AMOUNTS	80%	10%	10%♦

11 \*\*\*\*\*MEDICARE BENEFITS ARE SUBJECT TO CHANGE. PLEASE CONSULT THE  
 12 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 \$2,000  
 16 EACH CALENDAR YEAR. THE AMOUNTS THAT COUNT TOWARD YOUR ANNUAL  
 17 LIMIT ARE NOTED WITH DIAMONDS (♦) 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

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

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

5	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
6	HOSPITALIZATION**			
7	SEMIPRIVATE ROOM AND			
8	BOARD, GENERAL NURSING			
9	AND MISCELLANEOUS			
10	SERVICES AND SUPPLIES			
11	FIRST 60 DAYS	ALL BUT \$952	\$714	\$238 (25% OF
12			(75% OF	PART A
13			PART A	DEDUCTIBLE)♦
14			DEDUCTI-	
15			BLE)	
16	61ST THRU 90TH DAY	ALL BUT \$238	\$238	\$0
17		A DAY	A DAY	
18	91ST DAY AND AFTER:			
19	—WHILE USING 60			
20	LIFETIME RESERVE DAYS	ALL BUT \$476	\$476	\$0
21		A DAY	A DAY	
22	—ONCE LIFETIME RESERVE			
23	DAYS ARE USED:			
24	—ADDITIONAL 365 DAYS	\$0	100% OF	\$0***
25			MEDICARE	
26			ELIGIBLE	
27			EXPENSES	
28	—BEYOND THE			
29	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		
12		AMOUNTS	\$0	\$0
13	21ST THRU 100TH DAY	ALL BUT	UP TO	UP TO
14		\$119 A	\$89.25	\$29.75
15		DAY	A DAY	A DAY♦
16	101ST DAY AND AFTER	\$0	\$0	ALL COSTS
17	BLOOD			
18	FIRST 3 PINTS	\$0	75%	25%♦
19	ADDITIONAL AMOUNTS	100%	\$0	\$0
20	HOSPICE CARE			
21	AVAILABLE AS LONG AS YOUR	GENERALLY,	75% OF	25% OF
22	DOCTOR CERTIFIES YOU ARE	MOST MEDICARE	COINSUR-	COINSURANCE
23	TERMINALLY ILL AND YOU	ELIGIBLE	ANCE OR	OR COPAY-
24	ELECT TO RECEIVE THESE	EXPENSES FOR	COPAYMENTS	MENTS♦
25	SERVICES	OUTPATIENT		
26		DRUGS AND		
27		INPATIENT		
28		RESPITE CARE		

29 \*\*\*NOTICE: WHEN YOUR MEDICARE PART A HOSPITAL BENEFITS ARE  
30 EXHAUSTED, THE INSURER STANDS IN THE PLACE OF MEDICARE AND WILL

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

6

## PLAN L

7

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

8 \*\*\*\*ONCE YOU HAVE BEEN BILLED \$124 OF MEDICARE-APPROVED  
 9 AMOUNTS FOR COVERED SERVICES (WHICH ARE NOTED WITH AN ASTERISK),  
 10 YOUR PART B DEDUCTIBLE WILL HAVE BEEN MET FOR THE CALENDAR YEAR.

11	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
12	MEDICAL EXPENSES—			
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 \$124 OF			
25	MEDICARE APPROVED	\$0	\$0	\$124 (PART
26	AMOUNTS****			B DEDUCTI-

1				BLE)****◆
2	PREVENTIVE BENEFITS FOR	GENERALLY 75%	REMAINDER	ALL COSTS
3	MEDICARE COVERED	OR MORE OF	OF MEDI-	ABOVE MEDI-
4	SERVICES	MEDICARE	CARE	CARE
5		APPROVED	APPROVED	APPROVED
6		AMOUNTS	AMOUNTS	AMOUNTS
7	REMAINDER OF MEDICARE	GENERALLY	GENERALLY	GENERALLY
8	APPROVED AMOUNTS	80%	15%	5%◆
9	PART B EXCESS CHARGES	\$0	\$0	ALL COSTS
10	(ABOVE MEDICARE			(AND THEY DO
11	APPROVED AMOUNTS)			NOT COUNT
12				TOWARD
13				ANNUAL OUT-
14				OF-POCKET
15				LIMIT OF
16				\$2,000)*
17	BLOOD			
18	FIRST 3 PINTS	\$0	75%	25%◆
19	NEXT \$124 OF MEDICARE			
20	APPROVED AMOUNTS****	\$0	\$0	\$124
21				(PART B
22				DEDUCTIBLE)◆
23	REMAINDER OF MEDICARE	GENERALLY	GENERALLY	GENERALLY
24	APPROVED AMOUNTS	80%	15%	5%◆
25	CLINICAL LABORATORY			
26	SERVICES—TESTS FOR			
27	DIAGNOSTIC SERVICES	100%	\$0	\$0

28 \* THIS PLAN LIMITS YOUR ANNUAL OUT-OF-POCKET PAYMENTS FOR  
 29 MEDICARE-APPROVED AMOUNTS TO \$2,000 PER YEAR. HOWEVER, THIS LIMIT

1 DOES NOT INCLUDE CHARGES FROM YOUR PROVIDER THAT EXCEED MEDICARE-  
 2 APPROVED AMOUNTS (THESE ARE CALLED "EXCESS CHARGES") AND YOU WILL  
 3 BE RESPONSIBLE FOR PAYING THIS DIFFERENCE IN THE AMOUNT CHARGED  
 4 BY YOUR PROVIDER AND THE AMOUNT PAID BY MEDICARE FOR THE ITEM OR  
 5 SERVICE.

6 PARTS A & B

7	HOME HEALTH CARE			
8	MEDICARE APPROVED			
9	SERVICES			
10	—MEDICALLY NECESSARY			
11	SKILLED CARE SERVICES			
12	AND MEDICAL SUPPLIES	100%	\$0	\$0
13	—DURABLE MEDICAL			
14	EQUIPMENT			
15	FIRST \$124 OF MEDI-			
16	CARE APPROVED	\$0	\$0	\$124 (PART
17	AMOUNTS			B DEDUCTI-
18				BLE) ♦
19	REMAINDER OF MEDICARE			
20	APPROVED AMOUNTS	80%	15%	5% ♦

21 MEDICARE BENEFITS ARE SUBJECT TO CHANGE. PLEASE CONSULT THE  
 22 LATEST GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE.

23 Sec. 3817. (1) This section applies to medicare select  
 24 policies and certificates.

25 (2) As used in this section:

26 (a) "Complaint" means any dissatisfaction expressed by an  
 27 individual concerning a medicare select insurer or its network

1 providers.

2 (b) "Grievance" means a dissatisfaction expressed in writing  
3 by an individual insured under a medicare select policy or  
4 certificate with the administration, claims practices, or  
5 provision of services concerning a medicare select insurer or its  
6 network providers.

7 (c) "Medicare select insurer" means an insurer offering, or  
8 seeking to offer, a medicare select policy or certificate.

9 (d) "Medicare select policy" or "medicare select  
10 certificate" means a medicare supplement policy or certificate  
11 that contains restricted network provisions.

12 (e) "Network provider" means a provider of health care, or a  
13 group of providers of health care, that has entered into a  
14 written agreement with the insurer to provide benefits under a  
15 medicare select policy or certificate.

16 (f) "Restricted network provision" means any provision that  
17 conditions the payment of benefits, in whole or in part, on the  
18 use of network providers.

19 (g) "Service area" means the geographic area approved by the  
20 commissioner within which an insurer is authorized to offer a  
21 medicare select policy or certificate.

22 (3) A policy or certificate shall not be advertised as a  
23 medicare select policy or certificate unless it meets the  
24 requirements of this section.

25 (4) The commissioner may authorize an insurer to offer a  
26 medicare select policy or certificate, pursuant to this section  
27 and section 1882 of part C of title XVIII of the social security

1 act, ~~chapter 531, 49 Stat. 620, 42 U.S.C.~~ **USC** 1395ss, if the  
2 commissioner finds that the insurer has satisfied all necessary  
3 requirements.

4 (5) A medicare select insurer shall not issue a medicare  
5 select policy or certificate in this state until its plan of  
6 operation has been approved by the commissioner.

7 (6) A medicare select insurer shall file a proposed plan of  
8 operation with the commissioner in a format prescribed by the  
9 commissioner. The plan of operation shall contain at least the  
10 following information:

11 (a) Evidence that all covered services that are subject to  
12 restricted network provisions are available and accessible  
13 through network providers, as follows:

14 (i) That services can be provided by network providers with  
15 reasonable promptness with respect to geographic location, hours  
16 of operation, and after-hour care. The hours of operation and  
17 availability of after-hour care shall reflect usual practice in  
18 the local area. Geographic availability shall reflect the usual  
19 travel times within the community.

20 (ii) That the number of network providers in the service area  
21 is sufficient, with respect to current and expected  
22 policyholders, either to deliver adequately all services that are  
23 subject to a restricted network provision or to make appropriate  
24 referrals.

25 (iii) That there are written agreements with network providers  
26 describing specific responsibilities.

27 (iv) That emergency care is available 24 hours per day and 7

1 days per week.

2 (v) That in the case of covered services that are subject to  
3 a restricted network provision and are provided on a prepaid  
4 basis, there are written agreements with network providers  
5 prohibiting such providers from billing or otherwise seeking  
6 reimbursement from or recourse against any individual insured  
7 under a medicare select policy or certificate. This subparagraph  
8 does not apply to supplemental charges or coinsurance amounts as  
9 stated in the medicare select policy or certificate.

10 (b) A statement or map providing a clear description of the  
11 service area.

12 (c) A description of the grievance procedure to be used.

13 (d) A description of the quality assurance program,  
14 including all of the following:

15 (i) The formal organizational structure.

16 (ii) The written criteria for selection, retention, and  
17 removal of network providers.

18 (iii) The procedures for evaluating quality of care provided  
19 by network providers and the process to initiate corrective  
20 action if warranted.

21 (e) A list and description, by specialty, of the network  
22 providers.

23 (f) Copies of the written information proposed to be used by  
24 the insurer to comply with subsection (10).

25 (g) Any other information requested by the commissioner.

26 (7) A medicare select insurer shall file any proposed  
27 changes to the plan of operation, except for changes to the list

1 of network providers, with the commissioner prior to implementing  
2 any changes. An updated list of network providers shall be filed  
3 with the commissioner at least quarterly. Changes shall be  
4 considered approved by the commissioner after 30 days unless  
5 specifically disapproved.

6 (8) A medicare select policy or certificate shall not  
7 restrict payment for covered services provided by nonnetwork  
8 providers if the services are for symptoms requiring emergency  
9 care or are immediately required for an unforeseen illness,  
10 injury, or a condition and it is not reasonable to obtain such  
11 services through a network provider.

12 (9) A medicare select policy or certificate shall provide  
13 payment for full coverage under the policy or certificate for  
14 covered services that are not available through network  
15 providers.

16 (10) A medicare select insurer shall make full and fair  
17 disclosure in writing of the provisions, restrictions, and  
18 limitations of the medicare select policy or certificate to each  
19 applicant. This disclosure shall include at least all of the  
20 following:

21 (a) An outline of coverage sufficient to permit the  
22 applicant to compare the coverage and premiums of the medicare  
23 select policy or certificate with other medicare supplement  
24 policies or certificates offered by the insurer or offered by  
25 other insurers.

26 (b) A description, including address, phone number, and  
27 hours of operation, of the network providers, including primary



1 care physicians, specialty physicians, hospitals, and other  
2 providers.

3 (c) A description of the restricted network provisions,  
4 including payments for coinsurance and deductibles if providers  
5 other than network providers are utilized. **EXCEPT TO THE EXTENT**  
6 **SPECIFIED IN THE POLICY OR CERTIFICATE, EXPENSES INCURRED WHEN**  
7 **USING OUT-OF-NETWORK PROVIDERS DO NOT COUNT TOWARD THE OUT-OF-**  
8 **POCKET ANNUAL LIMIT CONTAINED IN PLANS K AND L.**

9 (d) A description of coverage for emergency and urgently  
10 needed care and other out-of-service area coverage.

11 (e) A description of limitations on referrals to restricted  
12 network providers and to other providers.

13 (f) A description of the policyholder's rights to purchase  
14 any other medicare supplement policy or certificate otherwise  
15 offered by the insurer.

16 (g) A description of the medicare select insurer's quality  
17 assurance program and grievance procedure.

18 (11) Prior to the sale of a medicare select policy or  
19 certificate, a medicare select insurer shall obtain from the  
20 applicant a signed and dated form stating that the applicant has  
21 received the information provided pursuant to subsection (10) and  
22 that the applicant understands the restrictions of the medicare  
23 select policy or certificate.

24 (12) A medicare select insurer shall have and use procedures  
25 for hearing complaints and resolving written grievances from  
26 subscribers. The procedures shall be aimed at mutual agreement  
27 for settlement and may include arbitration procedures. The

1 grievance procedure shall be described in the policy and  
2 certificate and in the outline of coverage. At the time the  
3 policy or certificate is issued, the insurer shall provide  
4 detailed information to the policyholder describing how a  
5 grievance may be registered with the insurer. Grievances shall be  
6 considered in a timely manner and shall be transmitted to  
7 appropriate decision-makers who have authority to fully  
8 investigate the issue and take corrective action. If a grievance  
9 is found to be valid, corrective action shall be taken promptly.  
10 All concerned parties shall be notified about the results of a  
11 grievance. The insurer shall report no later than each March 31  
12 to the commissioner regarding its grievance procedure. The report  
13 shall be in a format prescribed by the commissioner and shall  
14 contain the number of grievances filed in the past year and a  
15 summary of the subject, nature, and resolution of those  
16 grievances.

17 (13) At the time of initial purchase, a medicare select  
18 insurer shall make available to each applicant for a medicare  
19 select policy or certificate the opportunity to purchase any  
20 medicare supplement policy or certificate otherwise offered by  
21 the insurer.

22 (14) At the request of an individual insured under a  
23 medicare select policy or certificate, a medicare select insurer  
24 shall make available to the individual insured the opportunity to  
25 purchase a medicare supplement policy or certificate offered by  
26 the insurer that has comparable or lesser benefits and that does  
27 not contain a restricted network provision. The insurer shall

1 make the policies or certificates available without requiring  
2 evidence of insurability after the medicare supplement policy or  
3 certificate has been in force for 6 months. For the purposes of  
4 this subsection, a medicare supplement policy or certificate  
5 shall be considered to have comparable or lesser benefits unless  
6 it contains 1 or more significant benefits not included in the  
7 medicare select policy or certificate being replaced. For the  
8 purposes of this subsection, a significant benefit means coverage  
9 for the medicare part A deductible, ~~coverage for outpatient~~  
10 ~~prescription drugs,~~ coverage for at-home recovery services, or  
11 coverage for part B excess charges.

12 (15) Medicare select policies and certificates shall provide  
13 for continuation of coverage if the secretary of health and human  
14 services determines that medicare select policies and  
15 certificates issued pursuant to this section should be  
16 discontinued due to either the failure of the medicare select  
17 program to be reauthorized under law or its substantial  
18 amendment. Each medicare select insurer shall make available to  
19 each individual insured under a medicare select policy or  
20 certificate the opportunity to purchase any medicare supplement  
21 policy or certificate offered by the insurer that has comparable  
22 or lesser benefits and that does not contain a restricted network  
23 provision. The issuer shall make the policies and certificates  
24 available without requiring evidence of insurability. For the  
25 purposes of this subsection, a medicare supplement policy or  
26 certificate will be considered to have comparable or lesser  
27 benefits unless it contains 1 or more significant benefits not

1 included in the medicare select policy or certificate being  
2 replaced. For the purposes of this subsection, a significant  
3 benefit means coverage for the medicare part A deductible,  
4 ~~coverage for prescription drugs,~~ coverage for at-home recovery  
5 service, or coverage for part B excess charges.

6 (16) A medicare select insurer shall comply with reasonable  
7 requests for data made by state or federal agencies, including  
8 the United States department of health and human services, for  
9 the purposes of evaluating the medicare select program.

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

16 (2) The following standards apply to medicare supplement  
17 policies:

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

25 (b) A medicare supplement policy shall not indemnify against  
26 losses resulting from sickness on a different basis than losses  
27 resulting from accidents.

1 (c) A medicare supplement policy shall provide that benefits  
2 designed to cover cost sharing amounts under medicare will be  
3 changed automatically to coincide with any changes in the  
4 applicable medicare deductible amount and copayment percentage  
5 factors. Premiums may be modified to correspond with such  
6 changes.

7 (d) A medicare supplement policy shall be guaranteed  
8 renewable. Termination shall be for nonpayment of premium or  
9 material misrepresentation only.

10 (e) Termination of a medicare supplement policy shall not  
11 reduce or limit the payment of benefits for any continuous loss  
12 that commenced while the policy was in force, but the extension  
13 of benefits beyond the period during which the policy was in  
14 force may be predicated upon the continuous total disability of  
15 the insured, limited to the duration of the policy benefit  
16 period, if any, or payment of the maximum benefits. **RECEIPT OF**  
17 **MEDICARE PART D BENEFITS WILL NOT BE CONSIDERED IN DETERMINING A**  
18 **CONTINUOUS LOSS.**

19 **(F) IF A MEDICARE SUPPLEMENT POLICY ELIMINATES AN OUTPATIENT**  
20 **PRESCRIPTION DRUG BENEFIT AS A RESULT OF REQUIREMENTS IMPOSED BY**  
21 **THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION**  
22 **ACT OF 2003, PUBLIC LAW 108-173, THE MODIFIED POLICY SHALL BE**  
23 **CONSIDERED TO SATISFY THE GUARANTEED RENEWAL OF THIS SUBSECTION.**

24 **(G) —(f)—** A medicare supplement policy shall not provide for  
25 termination of coverage of a spouse solely because of the  
26 occurrence of an event specified for termination of coverage of  
27 the insured, other than the nonpayment of premium.

1       (3) A medicare supplement policy shall provide that benefits  
2 and premiums under the policy shall be suspended at the request  
3 of the policyholder or certificate holder for a period not to  
4 exceed 24 months in which the policyholder or certificate holder  
5 has applied for and is determined to be entitled to medical  
6 assistance under medicaid, but only if the policyholder or  
7 certificate holder notifies the insurer of such assistance within  
8 90 days after the date the individual becomes entitled to the  
9 assistance. Upon receipt of timely notice, the insurer shall  
10 return to the policyholder or certificate holder that portion of  
11 the premium attributable to the period of medicaid eligibility,  
12 subject to adjustment for paid claims. If a suspension occurs and  
13 if the policyholder or certificate holder loses entitlement to  
14 medical assistance under medicaid, the policy shall be  
15 automatically reinstituted effective as of the date of  
16 termination of the assistance if the policyholder or certificate  
17 holder provides notice of loss of medicaid medical assistance  
18 within 90 days after the date of the loss and pays the premium  
19 attributable to the period effective as of the date of  
20 termination of the assistance. Each medicare supplement policy  
21 shall provide that benefits and premiums under the policy shall  
22 be suspended at the request of the policyholder if the  
23 policyholder is entitled to benefits under section 226(b) of  
24 title II of the social security act, and is covered under a group  
25 health plan as defined in section 1862(b)(1)(A)(v) of the social  
26 security act. If suspension occurs and if the policyholder or  
27 certificate holder loses coverage under the group health plan,

1 the policy shall be automatically reinstituted effective as of  
2 the date of loss of coverage if the policyholder provides notice  
3 of loss of coverage within 90 days after the date of the loss and  
4 pays the premium attributable to the period, effective as of the  
5 date of termination of enrollment in the group health plan. All  
6 of the following apply to the reinstitution of a medicare  
7 supplement policy under this subsection:

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

10 (b) Reinstated coverage shall be substantially equivalent  
11 to coverage in effect before the date of the suspension. **IF THE**  
12 **SUSPENDED MEDICARE SUPPLEMENT POLICY PROVIDED COVERAGE FOR**  
13 **OUTPATIENT PRESCRIPTION DRUGS, REINSTITUTION OF THE POLICY FOR**  
14 **MEDICARE PART D ENROLLEES SHALL BE WITHOUT COVERAGE FOR**  
15 **OUTPATIENT PRESCRIPTION DRUGS AND SHALL OTHERWISE PROVIDE**  
16 **SUBSTANTIALLY EQUIVALENT COVERAGE TO THE COVERAGE IN EFFECT**  
17 **BEFORE THE DATE OF THE SUSPENSION.**

18 (c) Classification of premiums for reinstated coverage  
19 shall be on terms at least as favorable to the policyholder or  
20 certificate holder as the premium classification terms that would  
21 have applied to the policyholder or certificate holder had the  
22 coverage not been suspended.

23 Sec. 3823. (1) An insurance policy shall not be titled,  
24 advertised, solicited, or issued for delivery in this state as a  
25 medicare supplement policy unless the definitions and terms  
26 contained in the policy are such that covered benefits under the  
27 policy are not more restrictive than covered benefits under

1 medicare and those required to be provided under state law.

2 (2) A MEDICARE SUPPLEMENT POLICY WITH BENEFITS FOR  
3 OUTPATIENT PRESCRIPTION DRUGS IN EXISTENCE PRIOR TO JANUARY 1,  
4 2006 SHALL BE RENEWED FOR CURRENT POLICYHOLDERS WHO DO NOT ENROLL  
5 IN PART D AT THE OPTION OF THE POLICYHOLDER.

6 (3) A MEDICARE SUPPLEMENT POLICY WITH BENEFITS FOR  
7 OUTPATIENT PRESCRIPTION DRUGS SHALL NOT BE ISSUED AFTER DECEMBER  
8 31, 2005.

9 (4) AFTER DECEMBER 31, 2005, A MEDICARE SUPPLEMENT POLICY  
10 WITH BENEFITS FOR OUTPATIENT PRESCRIPTION DRUGS MAY NOT BE  
11 RENEWED AFTER THE POLICYHOLDER ENROLLS IN MEDICARE PART D UNLESS:

12 (A) THE POLICY IS MODIFIED TO ELIMINATE OUTPATIENT  
13 PRESCRIPTION COVERAGE FOR EXPENSES OF OUTPATIENT PRESCRIPTION  
14 DRUGS INCURRED AFTER THE EFFECTIVE DATE OF THE INDIVIDUAL'S  
15 COVERAGE UNDER A PART D PLAN.

16 (B) PREMIUMS ARE ADJUSTED TO REFLECT THE ELIMINATION OF  
17 OUTPATIENT PRESCRIPTION DRUG COVERAGE AT THE TIME OF MEDICARE  
18 PART D ENROLLMENT, ACCOUNTING FOR ANY CLAIMS PAID, IF APPLICABLE.

19 Sec. 3827. (1) A medicare supplement insurance policy or  
20 certificate shall not be delivered or issued for delivery in this  
21 state if the policy or certificate provides benefits that  
22 duplicate benefits provided by medicare.

23 (2) Application forms or a supplementary application or  
24 other form to be signed by the applicant and agent for medicare  
25 supplement policies shall include the following statements and  
26 questions designed to inform and elicit information as to  
27 whether, as of the date of the application, the applicant



1 **CURRENTLY** has ~~another~~ medicare supplement, **MEDICARE ADVANTAGE,**  
2 **MEDICAID COVERAGE,** or ~~other~~ **ANOTHER** health insurance policy or  
3 certificate in force or whether a medicare supplement policy or  
4 certificate is intended to replace any disability or other health  
5 policy or certificate presently in force:

6 [STATEMENTS]

7 (1) You do not need more than 1 medicare supplement policy.

8 (2) **IF YOUR PURCHASE THIS POLICY, YOU MAY WANT TO EVALUATE**  
9 **YOUR EXISTING HEALTH COVERAGE AND DECIDE IF YOU NEED MULTIPLE**  
10 **COVERAGES.**

11 (3) ~~—(2)—~~ If you are 65 or older, you may be eligible for  
12 benefits under medicaid and may not need a medicare supplement  
13 policy.

14 (4) ~~—(3)—The~~ **IF, AFTER PURCHASING THIS POLICY, YOU BECOME**  
15 **ELIGIBLE FOR MEDICAID, THE** benefits and premiums under your  
16 medicare supplement policy will be suspended during your  
17 entitlement to benefits under medicaid for 24 months. You must  
18 request this suspension within 90 days of becoming eligible for  
19 medicaid. If you are no longer entitled to medicaid, your  
20 **SUSPENDED MEDICARE SUPPLEMENT POLICY, OR, IF THAT IS NO LONGER**  
21 **AVAILABLE, A SUBSTANTIALLY EQUIVALENT** policy, will be  
22 reinstituted if requested within 90 days of losing medicaid  
23 eligibility. **IF THE MEDICARE SUPPLEMENT PROVIDED COVERAGE FOR**  
24 **OUTPATIENT PRESCRIPTION DRUGS AND YOU ENROLLED IN MEDICARE PART D**  
25 **WHILE YOUR POLICY WAS SUSPENDED, THE REINSTITUTED POLICY WILL NOT**  
26 **HAVE OUTPATIENT PRESCRIPTION DRUG COVERAGE, BUT WILL OTHERWISE BE**  
27 **SUBSTANTIALLY EQUIVALENT TO YOUR COVERAGE BEFORE THE DATE OF THE**

1 SUSPENSION.

2 (5) IF YOU ARE ELIGIBLE FOR, AND HAVE ENROLLED IN, A  
3 MEDICARE SUPPLEMENT POLICY BY REASON OF DISABILITY AND YOU LATER  
4 BECOME COVERED BY AN EMPLOYER OR UNION-BASED GROUP HEALTH PLAN,  
5 THE BENEFITS AND PREMIUMS UNDER YOUR MEDICARE SUPPLEMENT POLICY  
6 CAN BE SUSPENDED, IF REQUESTED, WHILE YOU ARE COVERED UNDER THE  
7 EMPLOYER OR UNION-BASED GROUP HEALTH PLAN. IF YOU SUSPEND YOUR  
8 MEDICARE SUPPLEMENT POLICY UNDER THESE CIRCUMSTANCES, AND LATER  
9 LOSE YOUR EMPLOYER OR UNION-BASED GROUP HEALTH PLAN, YOUR  
10 SUSPENDED MEDICARE SUPPLEMENT POLICY, OR IF THAT IS NO LONGER  
11 AVAILABLE, A SUBSTANTIALLY EQUIVALENT POLICY, WILL BE  
12 REINSTITUTED IF REQUESTED WITHIN 90 DAYS OF LOSING YOUR EMPLOYER  
13 OR UNION-BASED GROUP HEALTH PLAN. IF THE MEDICARE SUPPLEMENT  
14 POLICY PROVIDED COVERAGE FOR OUTPATIENT PRESCRIPTION DRUGS AND  
15 YOU ENROLLED IN MEDICARE PART D WHILE YOUR POLICY WAS SUSPENDED,  
16 THE REINSTITUTED POLICY WILL NOT HAVE OUTPATIENT PRESCRIPTION  
17 DRUG COVERAGE, BUT WILL OTHERWISE BE SUBSTANTIALLY EQUIVALENT TO  
18 YOUR COVERAGE BEFORE THE DATE OF THE SUSPENSION.

19 (6) ~~-(4)-~~ Counseling services may be available in your state  
20 to provide advice concerning your purchase of medicare supplement  
21 insurance and concerning medicaid.

22 [QUESTIONS]

23 ~~These questions should be answered to the best of your~~  
24 ~~knowledge.~~

25 ~~-(1) Do you have another medicare supplement insurance~~  
26 ~~policy, certificate, or contract in force (including a health~~  
27 ~~care corporation certificate or health maintenance organization~~

1 ~~contract)? If so, with which company?~~

2 ~~—— (2) Do you have any other health insurance policies,~~  
 3 ~~certificates, or contracts that provide benefits that this~~  
 4 ~~medicare supplement policy would duplicate? If so, with which~~  
 5 ~~company? What kind of policy, certificate, or contract?~~

6 ~~—— (3) If the answer to question 1 or 2 is yes, do you intend~~  
 7 ~~to replace these disability or health policies, certificates, or~~  
 8 ~~contracts with this policy or certificate?~~

9 ~~—— (4) Are you covered by medicaid?~~

10 IF YOU LOST OR ARE LOSING OTHER HEALTH INSURANCE COVERAGE  
 11 AND RECEIVED A NOTICE FROM YOUR PRIOR INSURER SAYING YOU WERE  
 12 ELIGIBLE FOR GUARANTEED ISSUE OF A MEDICARE SUPPLEMENT INSURANCE  
 13 POLICY, OR THAT YOU HAD CERTAIN RIGHTS TO BUY SUCH A POLICY, YOU  
 14 MAY BE GUARANTEED ACCEPTANCE IN ONE OR MORE OF OUR MEDICARE  
 15 SUPPLEMENT PLANS. PLEASE INCLUDE A COPY OF THE NOTICE FROM YOUR  
 16 PRIOR INSURER WITH YOUR APPLICATION. PLEASE ANSWER ALL QUESTIONS.

17 [PLEASE MARK YES OR NO BELOW WITH AN "X"]

18 TO THE BEST OF YOUR KNOWLEDGE,

19

20 (1) (A) DID YOU TURN AGE 65 IN THE LAST 6 MONTHS?

21 YES \_\_\_\_ NO \_\_\_\_

22 (B) DID YOU ENROLL IN MEDICARE PART B IN THE LAST 6  
 23 MONTHS?

24 YES \_\_\_\_ NO \_\_\_\_

25 (C) IF YES, WHAT IS THE EFFECTIVE DATE? \_\_\_\_\_

26 (2) ARE YOU COVERED FOR MEDICAL ASSISTANCE THROUGH THE  
 27 STATE MEDICAID PROGRAM?

28 [NOTE TO APPLICANT: IF YOU ARE PARTICIPATING IN A

1 "SPEND-DOWN PROGRAM" AND HAVE NOT MET YOUR "SHARE  
2 OF COST," PLEASE ANSWER NO TO THIS QUESTION.]

3 YES \_\_\_\_\_ NO \_\_\_\_\_

4 IF YES,

5 (A) WILL MEDICAID PAY YOUR PREMIUMS FOR THIS MEDICARE  
6 SUPPLEMENT POLICY?

7 YES \_\_\_\_\_ NO \_\_\_\_\_

8 (B) DO YOU RECEIVE ANY BENEFITS FROM MEDICAID OTHER  
9 THAN PAYMENTS TOWARD YOUR MEDICARE PART B PREMIUM?

10 YES \_\_\_\_\_ NO \_\_\_\_\_

11 (3) (A) IF YOU HAD COVERAGE FROM ANY MEDICARE PLAN OTHER  
12 THAN ORIGINAL MEDICARE WITHIN THE PAST 63 DAYS (FOR  
13 EXAMPLE, A MEDICARE ADVANTAGE PLAN, OR A MEDICARE  
14 HMO OR PPO), FILL IN YOUR START AND END DATES  
15 BELOW. IF YOU ARE STILL COVERED UNDER THIS PLAN,  
16 LEAVE "END" BLANK.

17 START \_\_\_\_/\_\_\_\_/\_\_\_\_ END \_\_\_\_/\_\_\_\_/\_\_\_\_

18 (B) IF YOU ARE STILL COVERED UNDER THE MEDICARE PLAN,  
19 DO YOU INTEND TO REPLACE YOUR CURRENT COVERAGE  
20 WITH THIS NEW MEDICARE SUPPLEMENT POLICY?

21 YES \_\_\_\_\_ NO \_\_\_\_\_

22 (C) WAS THIS YOUR FIRST TIME IN THIS TYPE OF MEDICARE  
23 PLAN?

24 YES \_\_\_\_\_ NO \_\_\_\_\_

25 (D) DID YOU DROP A MEDICARE SUPPLEMENT POLICY TO ENROLL  
26 IN THE MEDICARE PLAN?

27 YES \_\_\_\_\_ NO \_\_\_\_\_

28 (4) (A) DO YOU HAVE ANOTHER MEDICARE SUPPLEMENT POLICY IN  
29 FORCE?

30 YES \_\_\_\_\_ NO \_\_\_\_\_

31 (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 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?

---

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(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 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, 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 delivery of the policy or certificate.

1       (5) Upon determining that a sale will involve replacement of  
2 medicare supplement coverage, an insurer, other than a direct  
3 response insurer or its agent, shall furnish the applicant prior  
4 to issuance or delivery of the medicare supplement policy the  
5 following notice regarding replacement of medicare supplement  
6 coverage. One copy of the notice signed by the applicant and the  
7 agent, except where coverage is sold without an agent, shall be  
8 provided to the applicant and an additional signed copy shall be  
9 retained by the insurer. A direct response insurer shall deliver  
10 to the applicant at the time of issuance of the policy or  
11 certificate the following notice, regarding replacement of  
12 medicare supplement coverage. The notice regarding replacement of  
13 medicare supplement coverage shall be provided in substantially  
14 the following form and in not less than ~~10-point~~ **12-POINT** type:

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

19       According to (your application) (information you have  
20 furnished), you intend to drop or otherwise terminate existing  
21 medicare supplement coverage **OR MEDICARE ADVANTAGE PLAN** and  
22 replace it with a policy or certificate to be issued by (company  
23 name) insurance company. Your new policy or certificate provides  
24 30 days within which you may decide without cost whether you  
25 desire to keep the policy or certificate.

26       You should review this new coverage carefully comparing it

1 with all disability and other health coverage you now have and  
 2 terminate your present coverage only if, after due consideration,  
 3 you find that purchase of this medicare supplement coverage is a  
 4 wise decision.

5 Statement to applicant by insurer, agent, or other  
 6 representative:

7 (Use additional sheets as necessary.)

8 I have reviewed your current medical or health coverage. The  
 9 replacement of coverage involved in this transaction does not  
 10 duplicate ~~coverage~~ **YOUR EXISTING MEDICARE SUPPLEMENT, OR, IF**  
 11 **APPLICABLE, MEDICARE ADVANTAGE COVERAGE BECAUSE YOU INTEND TO**  
 12 **TERMINATE YOUR EXISTING MEDICARE SUPPLEMENT COVERAGE OR LEAVE**  
 13 **YOUR MEDICARE ADVANTAGE PLAN**, to the best of my knowledge. The  
 14 replacement policy is being purchased for the following reasons  
 15 (check 1):

16 \_\_\_\_\_ Additional benefits

17 \_\_\_\_\_ No change in benefits, but lower premiums

18 \_\_\_\_\_ Fewer benefits and lower premiums

19 \_\_\_\_\_ **MY PLAN HAS OUTPATIENT PRESCRIPTION DRUG COVERAGE AND**  
 20 **I AM ENROLLING IN PART D**

21 \_\_\_\_\_ **DISENROLLMENT FROM A MEDICARE ADVANTAGE PLAN. PLEASE**  
 22 **EXPLAIN REASON FOR DISENROLLMENT. [OPTIONAL ONLY FOR DIRECT**  
 23 **MAILERS.]**

24 \_\_\_\_\_ Other. (Please specify)

25 1. Health conditions which you may presently have (pre-  
 26 existing conditions) may not be immediately or fully covered  
 27 under the new policy. This could result in denial or delay of a

1 claim for benefits under the new policy, whereas a similar claim  
2 might have been payable under your present policy. This paragraph  
3 may be deleted by an insurer if the replacement does not involve  
4 application of a new pre-existing condition limitation.

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

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

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

25 \_\_\_\_\_  
26 Signature of Agent, Broker, or Other Representative  
27 (\* Signature not required for direct response sales.)



1 \_\_\_\_\_  
 2 Typed Name and Address of Agent or Broker  
 3 \_\_\_\_\_  
 4 (Date)

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

6 \_\_\_\_\_  
 7 (Date)  
 8 \_\_\_\_\_

9 \_\_\_\_\_  
 10 (Applicant's Signature)  
 11 \_\_\_\_\_

12 \_\_\_\_\_  
 13 (Applicant's Printed Name)  
 14 \_\_\_\_\_

15 \_\_\_\_\_  
 16 (Applicant's Address)  
 17 \_\_\_\_\_

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

19 Sec. 3830. (1) An eligible person is an individual described  
 20 in subsection (2) who applies to enroll under a medicare  
 21 supplement policy during the period described in subsection (3),  
 22 and who submits evidence of the date of termination or  
 23 disenrollment **OR MEDICARE PART D ENROLLMENT** with the application  
 24 for a medicare supplement policy. For an eligible person, an  
 25 insurer shall not deny or condition the issuance or effectiveness  
 26 of a medicare supplement policy described in subsections (5),  
 27 (6), and (7) that is offered and is available for issuance to new  
 28 enrollees by the insurer, shall not discriminate in the pricing  
 29 of the medicare supplement policy because of health status,  
 claims experience, receipt of health care, or medical condition,  
 and shall not impose an exclusion of benefits based on a  
 preexisting condition under the medicare supplement policy.

(2) An eligible person under this section is an individual

1 that meets any of the following:

2 (a) Is enrolled under an employee welfare benefit plan that  
3 provides health benefits that supplement the benefits under  
4 medicare and the plan terminates or the plan ceases to provide  
5 all those supplemental health benefits to the individual.

6 (b) Is enrolled with a ~~medicare+choice~~ **MEDICARE ADVANTAGE**  
7 organization under a ~~medicare+choice~~ **MEDICARE ADVANTAGE** plan  
8 under part C of medicare, and any of the following circumstances  
9 apply, or the individual is 65 years of age or older and is  
10 enrolled with a PACE provider under section 1894 of the social  
11 security act, and there are circumstances similar to those  
12 described below that would permit discontinuance of the  
13 individual's enrollment with the provider if the individual were  
14 enrolled in a ~~medicare+choice~~ **MEDICARE ADVANTAGE** plan:

15 (i) The certification of the organization or plan has been  
16 terminated.

17 (ii) The organization has terminated or otherwise  
18 discontinued providing the plan in the area in which the  
19 individual resides.

20 (iii) The individual is no longer eligible to elect the plan  
21 because of a change in the individual's place of residence or  
22 other change in circumstances specified by the secretary, but not  
23 including termination of the individual's enrollment on the basis  
24 described in section 1851(g)(3)(b) of the social security act,  
25 where the individual has not paid premiums on a timely basis or  
26 has engaged in disruptive behavior as specified in standards  
27 established under section 1856 of the social security act, or the

1 plan is terminated for all individuals within a residence area.

2 (iv) The individual demonstrates, in accordance with  
3 guidelines established by the secretary, that the organization  
4 offering the plan substantially violated a material provision of  
5 the organization's contract in relation to the individual,  
6 including the failure to provide an enrollee on a timely basis  
7 medically necessary care for which benefits are available under  
8 the plan or the failure to provide covered care in accordance  
9 with applicable quality standards, or the organization, or agent  
10 or other entity acting on the organization's behalf, materially  
11 misrepresented the plan's provisions in marketing the plan to the  
12 individual.

13 (v) The individual meets other exceptional conditions as the  
14 secretary may provide.

15 (c) Is enrolled with an eligible organization under a  
16 contract under section 1876 of the social security act, a similar  
17 organization operating under demonstration project authority,  
18 effective for periods before April 1, 1999, an organization under  
19 an agreement under section 1833(a)(1)(A) of the social security  
20 act, health care prepayment plan, or an organization under a  
21 medicare select policy, and the enrollment ceases under the same  
22 circumstances that would permit discontinuance of an individual's  
23 election of coverage under subdivision (b).

24 (d) Is enrolled under a medicare supplement policy and the  
25 enrollment ceases because of any of the following:

26 (i) The insolvency of the insurer or bankruptcy of the  
27 noninsurer organization or of other involuntary termination of

1 coverage or enrollment under the policy.

2 (ii) The insurer substantially violated a material provision  
3 of the policy.

4 (iii) The insurer, or an agent or other entity acting on the  
5 insurer's behalf, materially misrepresented the policy's  
6 provisions in marketing the policy to the individual.

7 (e) Was enrolled under a medicare supplement policy and  
8 terminates enrollment and subsequently enrolls, for the first  
9 time, with any ~~medicare+choice~~ **MEDICARE ADVANTAGE** organization  
10 under a ~~medicare+choice~~ **MEDICARE ADVANTAGE** plan under part C of  
11 medicare, any eligible organization under a contract under  
12 section 1876 of the social security act, medicare cost, any  
13 similar organization operating under demonstration project  
14 authority, any PACE provider under section 1894 of the social  
15 security act, or a medicare select policy; and the subsequent  
16 enrollment is terminated by the enrollee during any period within  
17 the first 12 months of the subsequent enrollment during which the  
18 enrollee is permitted to terminate the subsequent enrollment  
19 under section 1851(e) of the social security act.

20 (f) Upon first becoming eligible for benefits under part A  
21 of medicare at age 65, enrolls in a ~~medicare+choice~~ **MEDICARE**  
22 **ADVANTAGE** plan under part C of medicare, or with a PACE provider  
23 under section 1894 of the social security act, and disenrolls  
24 from the plan or program by not later than 12 months after the  
25 effective date of enrollment.

26 (G) **ENROLLS IN A MEDICARE PART D PLAN DURING THE INITIAL**  
27 **ENROLLMENT PERIOD AND, AT THE TIME OF ENROLLMENT IN PART D, WAS**

1 ENROLLED UNDER A MEDICARE SUPPLEMENT POLICY THAT COVERS  
2 OUTPATIENT PRESCRIPTION DRUGS AND THE INDIVIDUAL TERMINATES  
3 ENROLLMENT IN THE MEDICARE SUPPLEMENT POLICY AND SUBMITS EVIDENCE  
4 OF ENROLLMENT IN MEDICARE PART D ALONG WITH THE APPLICATION FOR A  
5 POLICY DESCRIBED IN SUBSECTION (5).

6 (3) The guaranteed issue time periods under this section are  
7 as follows:

8 (a) For an individual described in subsection (2)(a), the  
9 guaranteed issue time period begins on the date the individual  
10 receives a notice of termination or cessation of all supplemental  
11 health benefits or, if a notice is not received, notice that a  
12 claim has been denied because of a termination or cessation, **OR**  
13 **THE DATE THAT THE APPLICABLE COVERAGE TERMINATES OR CEASES,**  
14 **WHICHEVER OCCURS LATER,** and ends 63 days after ~~the~~ **THAT** date.  
15 ~~of the applicable notice.~~

16 (b) For an individual described in subsection (2)(b), (c),  
17 (e), or (f) whose enrollment is terminated involuntarily, the  
18 guaranteed issue time period begins on the date that the  
19 individual receives a notice of termination and ends 63 days  
20 after the date the applicable coverage is terminated.

21 (c) For an individual described in subsection (2)(d)(i), the  
22 guaranteed issue time period begins on the earlier of the date  
23 that the individual receives a notice of termination, a notice of  
24 the issuer's bankruptcy or insolvency, or other such similar  
25 notice, if any, or the date that the applicable coverage is  
26 terminated, and ends on the date that is 63 days after the date  
27 the coverage is terminated.

(d) For an individual described in subsection (2)(b), (d)(ii), (d)(iii), (e), or (f) who disenrolls voluntarily, the guaranteed issue time period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

**(E) IN THE CASE OF AN INDIVIDUAL DESCRIBED IN SUBSECTION (2)(G), THE GUARANTEED ISSUE PERIOD BEGINS ON THE DATE THE INDIVIDUAL RECEIVES NOTICE PURSUANT TO SECTION 1882(V)(2)(B) OF THE SOCIAL SECURITY ACT FROM THE MEDICARE SUPPLEMENT ISSUER DURING THE 60-DAY PERIOD IMMEDIATELY PRECEDING THE INITIAL PART D ENROLLMENT PERIOD AND ENDS ON THE DATE THAT IS 63 DAYS AFTER THE EFFECTIVE DATE OF THE INDIVIDUAL'S COVERAGE UNDER MEDICARE PART D.**

**(F) —(e)—** For an individual described in subsection (2) but not described in subdivisions (a) to (d), the guaranteed issue time period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(4) For an individual described in subsection (2)(e) whose enrollment with an organization or provider described in subsection (2)(e) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be considered an initial enrollment described in subsection (2)(e). For an individual described in subsection (2)(f) whose enrollment within a plan or in a program described in subsection (2)(f) is involuntarily terminated within the first 12 months of enrollment, and who, without an

1 intervening enrollment, enrolls in another such plan or program,  
 2 the subsequent enrollment shall be considered an initial  
 3 enrollment described in subsection (2)(f). For purposes of  
 4 subsections (2)(e) and (f), an enrollment of an individual with  
 5 an organization or provider described in subsection (2)(e), or  
 6 with a plan or provider described in subsection (2)(f), shall not  
 7 be considered to be an initial enrollment after the 2-year period  
 8 beginning on the date on which the individual first enrolled with  
 9 such an organization, provider, or plan.

10 (5) ~~The~~ **SUBJECT TO THIS SUBSECTION, THE** medicare  
 11 supplement policy to which an eligible person is entitled under  
 12 subsection (2)(a), (b), (c), and (d) is a medicare supplement  
 13 policy that has a benefit package classified as plan A, B, C, or  
 14 F ~~offered by any insurer~~ **INCLUDING F WITH A HIGH DEDUCTIBLE, K,**  
 15 **OR L OFFERED BY ANY INSURER. AFTER DECEMBER 31, 2005, IF THE**  
 16 **INDIVIDUAL WAS MOST RECENTLY ENROLLED IN A MEDICARE SUPPLEMENT**  
 17 **POLICY WITH AN OUTPATIENT PRESCRIPTION DRUG BENEFIT, A MEDICARE**  
 18 **SUPPLEMENT POLICY DESCRIBED IN THIS SUBSECTION IS:**

19 (A) **THE POLICY AVAILABLE FROM THE SAME INSURER BUT MODIFIED**  
 20 **TO REMOVE OUTPATIENT PRESCRIPTION DRUG COVERAGE.**

21 (B) **AT THE ELECTION OF THE POLICYHOLDER, AN A, B, C, F,**  
 22 **INCLUDING F WITH A HIGH DEDUCTIBLE, K, OR L POLICY THAT IS**  
 23 **OFFERED BY ANY INSURER.**

24 (6) The medicare supplement policy to which an eligible  
 25 person is entitled under subsection (2)(e) is the same medicare  
 26 supplement policy in which the individual was most recently  
 27 previously enrolled, if available from the same insurer, or, if

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 1 not so available, a policy described in subsection (5).

2 (7) The medicare supplement policy to which an eligible  
 3 person is entitled under subsection (2)(f) shall include any  
 4 medicare supplement policy offered by any insurer.

5 (8) SUBSECTION (2)(G) IS A MEDICARE SUPPLEMENT POLICY THAT  
 6 HAS A BENEFIT PACKAGE CLASSIFIED AS PLAN A, B, C, F, INCLUDING F  
 7 WITH A HIGH DEDUCTIBLE, K, OR L, AND THAT IS OFFERED AND IS  
 8 AVAILABLE FOR ISSUANCE TO NEW ENROLLEES BY THE SAME INSURER THAT  
 9 ISSUED THE INDIVIDUAL'S MEDICARE SUPPLEMENT POLICY WITH  
 10 OUTPATIENT PRESCRIPTION DRUG COVERAGE.

[Sec. 3831. (1) Each insurer offering individual or group expense incurred hospital, medical, or surgical policies or certificates in this state shall provide without restriction, to any person who requests coverage from an insurer and has been insured with an insurer subject to this section, if the person would no longer be insured because he or she has become eligible for medicare or if the person loses coverage under a group policy after becoming eligible for medicare, a right of continuation or conversion to their choice of the basic core benefits as described in section 3807 or a type C medicare supplemental package as described in section 3811(5)(c) that is guaranteed renewable or noncancellable. A person who is hospitalized or has been informed by a physician that he or she will require hospitalization within 30 days after the time of application shall not be entitled to coverage under this subsection until the day following the date of discharge. However, if the hospitalized person was insured by the insurer immediately prior to becoming eligible for medicare or immediately prior to losing coverage under a group policy after becoming eligible for medicare, the person shall be eligible for immediate coverage from the previous insurer under this subsection. A person shall not be entitled to a medicare supplemental policy under this subsection unless the person presents satisfactory proof to the insurer that he or she was insured with an insurer subject to this section. A person who wishes coverage under this subsection must either request coverage within 90 days before or 90 days after the month he or she becomes eligible for medicare or request coverage within 180 days after losing coverage under a group policy. A person 60 years of age or older who loses coverage under a group policy is entitled to coverage under a medicare supplemental policy without restriction from the insurer providing the former group coverage, if he or she requests coverage within 90 days before or 90 days after the month he or she becomes eligible for medicare.

(2) Except as provided in section 3833, a person not insured under an individual or group hospital, medical, or surgical expense incurred policy as specified in subsection (1), after applying for coverage under a medicare supplemental policy required to be offered under subsection (1), shall be entitled to coverage under a medicare supplemental policy that may include a provision for exclusion from preexisting conditions for 6 months after the



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inception of coverage, consistent with the provisions of section 3819(2)(a).

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

(4) NOTWITHSTANDING THE REQUIREMENTS OF THIS SECTION, AN INSURER OFFERING OR RENEWING INDIVIDUAL OR GROUP EXPENSE INCURRED HOSPITAL, MEDICAL, OR SURGICAL POLICIES OR CERTIFICATES AFTER JUNE 27, 2005 MAY COMPLY WITH THE REQUIREMENT OF PROVIDING MEDICARE SUPPLEMENTAL COVERAGE TO ELIGIBLE POLICYHOLDERS BY UTILIZING ANOTHER INSURER TO WRITE THIS COVERAGE PROVIDED THE INSURER MEETS ALL OF THE FOLLOWING REQUIREMENTS:

(A) THE INSURER PROVIDES ITS POLICYHOLDERS THE NAME OF THE INSURER THAT WILL PROVIDE THE MEDICARE SUPPLEMENTAL COVERAGE.

(B) THE INSURER GIVES ITS POLICYHOLDERS THE TELEPHONE NUMBERS AT WHICH THE MEDICARE SUPPLEMENTAL INSURER CAN BE REACHED.

(C) THE INSURER REMAINS RESPONSIBLE FOR PROVIDING MEDICARE SUPPLEMENTAL COVERAGE TO ITS POLICYHOLDERS IN THE EVENT THAT 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 IDENTIFY THE PROCESS PROVIDED IN SUBDIVISIONS (A) THROUGH (C) AND SHALL CLEARLY STATE THAT THE INSURER UNDERSTANDS THAT THE COMMISSIONER MAY VOID THIS ARRANGEMENT IF THE AFFILIATE FAILS TO ENSURE THAT ELIGIBLE POLICYHOLDERS ARE IMMEDIATELY OFFERED MEDICARE SUPPLEMENTAL POLICIES.

(E) THE INSURER CERTIFIES TO THE COMMISSIONER THAT IT IS IN THE PROCESS OF DISCONTINUING IN MICHIGAN ITS OFFERING OF INDIVIDUAL OR GROUP EXPENSE INCURRED HOSPITAL, MEDICAL, OR SURGICAL POLICIES OR CERTIFICATES.]

11 Sec. 3835. (1) Each insurer marketing medicare supplement

12 insurance coverage in this state directly or through its agents

13 shall do all of the following:

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

16 (b) Establish marketing procedures to ensure excessive  
17 insurance is not sold or issued.

18 (c) Inquire and otherwise make every reasonable effort to  
19 identify whether a prospective applicant for medicare supplement  
20 insurance already has disability or other health coverage and the

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21 types and amounts of coverage.

22 (d) Establish auditable procedures for verifying compliance  
23 with this subsection.

24 (2) In recommending the purchase or replacement of any  
25 medicare supplement coverage, an agent shall make reasonable  
26 efforts to determine the appropriateness of a recommended  
27 purchase or replacement.

1       (3) Any sale of medicare supplement coverage that will  
2 provide an individual with more than 1 medicare supplement  
3 policy, certificate, or contract is prohibited.

4       **(4) AN INSURER SHALL NOT ISSUE A MEDICARE SUPPLEMENT POLICY**  
5 **OR CERTIFICATE TO AN INDIVIDUAL ENROLLED IN MEDICARE ADVANTAGE**  
6 **UNLESS THE EFFECTIVE DATE OF THE COVERAGE IS AFTER THE**  
7 **TERMINATION DATE OF THE INDIVIDUAL'S MEDICARE ADVANTAGE COVERAGE.**

8       (5) ~~—(4)—~~ A medical supplement policy shall display  
9 prominently by type, stamp, or other appropriate means, on the  
10 first page of the policy the following: "Notice to buyer: This  
11 policy may not cover all of your medical expenses.".

12       Sec. 3839. (1) Each medicare supplement policy shall include  
13 a renewal or continuation provision. The provision shall be  
14 appropriately captioned, shall appear on the first page of the  
15 policy, and shall clearly state the term of coverage for which  
16 the policy is issued and for which it may be renewed. The  
17 provision shall include any reservation by the insurer of the  
18 right to change premiums and any automatic renewal premium  
19 increases based on the policyholder's age.

20       (2) If a medicare supplement policy is terminated by the  
21 group policyholder and is not replaced as provided under  
22 subsection (4), the issuer shall offer certificate holders an  
23 individual medicare supplement policy that at the option of the  
24 certificate holder provides for continuation of the benefits  
25 contained in the group policy or provides for such benefits as  
26 otherwise meet the requirements of section 3819.

27       (3) If an individual is a certificate holder in a group

1 medicare supplement policy and the individual terminates  
2 membership in the group, the issuer shall offer the certificate  
3 holder the conversion opportunity described in subsection (4) or  
4 at the option of the group policyholder, offer the certificate  
5 holder continuation of coverage under the group policy.

6 (4) If a group medicare supplement policy is replaced by  
7 another group medicare supplement policy purchased by the same  
8 policyholder, the succeeding issuer shall offer coverage to all  
9 persons covered under the old group policy on its date of  
10 termination. Coverage under the new policy shall not result in  
11 any exclusion for preexisting conditions that would have been  
12 covered under the group policy being replaced.

13 (5) IF A MEDICARE SUPPLEMENT POLICY ELIMINATES AN OUTPATIENT  
14 PRESCRIPTION DRUG BENEFIT AS A RESULT OF REQUIREMENTS IMPOSED BY  
15 THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION  
16 ACT OF 2003, PUBLIC LAW 108-173, THE MODIFIED POLICY SHALL BE  
17 CONSIDERED TO SATISFY THE GUARANTEED RENEWAL REQUIREMENTS OF THIS  
18 SECTION.

19 Sec. 3841. (1) Except for riders or endorsements by which  
20 the insurer effectuates a request made in writing by the insured,  
21 exercises a specifically reserved right under a medicare  
22 supplement policy, or as required to reduce or eliminate benefits  
23 to avoid duplication of medicare benefits, all riders or  
24 endorsements added to a medicare supplement policy after date of  
25 issue or at reinstatement or renewal that reduce or eliminate  
26 benefits or coverage in the policy shall require signed  
27 acceptance by the insured. After the date of policy issue, any

1 rider or endorsement that increases benefits or coverage with a  
2 concomitant increase in premium during the policy term shall be  
3 agreed to in writing and signed by the insured, unless the  
4 benefits are required minimum standards for medicare supplement  
5 policies or if the increase in benefits or coverage is required  
6 by law. If a separate additional premium is charged for benefits  
7 provided in connection with riders or endorsements, the premium  
8 charged shall be set forth in the policy.

9 (2) A medicare supplement policy shall not provide for the  
10 payment of benefits based on standards described as "usual and  
11 customary", "reasonable and customary", or words of similar  
12 import.

13 (3) If a medicare supplement policy contains any limitations  
14 with respect to preexisting conditions, the limitations shall  
15 appear as a separate paragraph of the policy and shall be labeled  
16 as "preexisting condition limitations".

17 (4) The term "medicare supplement", "medigap", "medicare  
18 wrap-around", or words of similar import shall not be used unless  
19 the policy is issued in compliance with this chapter.

20 (5) As soon as practicable but prior to the effective date  
21 of any changes in medicare benefits, every insurer offering  
22 medicare supplement insurance policies in this state shall file  
23 with the commissioner both of the following:

24 (a) Any appropriate premium adjustments necessary to produce  
25 loss ratios as anticipated for the current premium for the  
26 applicable policies and any supporting documents necessary to  
27 justify the adjustment.

1 (b) Any appropriate riders, endorsements, or policy forms  
2 needed to accomplish the medicare supplement insurance  
3 modifications necessary to eliminate benefits under the policy or  
4 certificate that duplicate benefits provided by medicare. The  
5 riders, endorsements, and policy forms shall provide a clear  
6 description of the medicare supplement benefits provided by the  
7 policy.

8 (6) Upon satisfying the filing and approval requirements, an  
9 insurer providing medicare supplement policies delivered or  
10 issued for delivery in this state shall provide to each covered  
11 policyholder any rider, endorsement, or policy form necessary to  
12 eliminate benefits under the policy that duplicate benefits  
13 provided by medicare.

14 (7) As soon as practicable but no later than 30 days before  
15 the annual effective date of any medicare benefit changes, every  
16 insurer of medicare supplement policies delivered or issued for  
17 delivery in this state shall notify each covered policyholder or  
18 certificate holder of modifications made to its medicare  
19 supplement policies in a format acceptable to the commissioner.  
20 The notice shall be in outline form, contain clear and simple  
21 language, shall not contain or be accompanied by any  
22 solicitation, and shall include both of the following:

23 (a) A description of revisions to the medicare program and  
24 of each modification made to the coverage provided under the  
25 medicare supplement policy.

26 (b) Whether a premium adjustment is due to changes in  
27 medicare.

1       (8) INSURERS SHALL COMPLY WITH ANY NOTICE REQUIREMENTS OF  
2 THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION  
3 ACT OF 2003, PUBLIC LAW 108-173.

4       Sec. 3849. (1) An insurer shall not deliver or issue for  
5 delivery a medicare supplement policy to a resident of this state  
6 unless the policy form or certificate form has been filed with  
7 and approved by the commissioner in accordance with filing  
8 requirements and procedures prescribed by the commissioner.

9       (2) AN INSURER SHALL FILE ANY RIDERS OR AMENDMENTS TO POLICY  
10 OR CERTIFICATE FORMS TO DELETE OUTPATIENT PRESCRIPTION DRUG  
11 BENEFITS AS REQUIRED BY THE MEDICARE PRESCRIPTION DRUG,  
12 IMPROVEMENT, AND MODERNIZATION ACT OF 2003, PUBLIC LAW 108-173,  
13 ONLY WITH THE COMMISSIONER IN THE STATE IN WHICH THE POLICY OR  
14 CERTIFICATE WAS ISSUED.

15       (3) ~~—(2)—~~ An insurer shall not use or change premium rates  
16 for a medicare supplement policy unless the rates, rating  
17 schedule, and supporting documentation have been filed with and  
18 approved by the commissioner in accordance with the filing  
19 requirements and procedures prescribed by the commissioner.

20       (4) ~~—(3)—~~ Except as provided in subsection ~~—(4)—~~ (5), an  
21 insurer shall not file for approval more than 1 form of a policy  
22 or certificate for each individual policy and group policy  
23 standard medicare supplement benefit plan.

24       (5) ~~—(4)—~~ With the approval of the commissioner, an issuer  
25 may offer up to 4 additional policy forms or certificate forms of  
26 the same type for the same standard medicare supplement benefit  
27 plan, 1 for each of the following cases:

1 (a) The inclusion of new or innovative benefits.

2 (b) The addition of either direct response or agent  
3 marketing methods.

4 (c) The addition of either guaranteed issue or underwritten  
5 coverage.

6 (d) The offering of coverage to individuals eligible for  
7 medicare by reason of disability.

8 (6) ~~—(5)—~~ Except as provided in subsection ~~—(6)—~~ (7), an  
9 insurer shall continue to make available for purchase any  
10 medicare supplement policy form or certificate form issued after  
11 the effective date of this chapter that has been approved by the  
12 commissioner. A medicare supplement policy form or certificate  
13 form shall not be considered to be available for purchase unless  
14 the insurer has actively offered it for sale in the previous 12  
15 months.

16 (7) ~~—(6)—~~ An insurer may discontinue the availability of a  
17 medicare supplement policy form or certificate form if the  
18 insurer provides to the commissioner in writing its decision to  
19 discontinue at least 30 days prior to discontinuing the  
20 availability of the form of the medicare supplement policy. After  
21 receipt of the notice by the commissioner, the insurer shall no  
22 longer offer for sale the medicare supplement policy form or  
23 certificate form in this state.

24 (8) ~~—(7)—~~ An insurer that discontinues the availability of a  
25 medicare supplement policy form or certificate form pursuant to  
26 subsection ~~—(6)—~~ (7) shall not file for approval a new medicare  
27 supplement policy form or certificate form of the same type for



1 the same standard medicare supplement benefit plan as the  
2 discontinued form for a period of 5 years after the insurer  
3 provides notice to the commissioner of the discontinuance. The  
4 period of discontinuance may be reduced if the commissioner  
5 determines that a shorter period is appropriate.

6       **(9)** ~~—(8)—~~ The sale or other transfer of medicare supplement  
7 business to another insurer shall be considered a discontinuance  
8 for the purposes of this section. In addition, a change in the  
9 rating structure or methodology shall be considered a

10 discontinuance under this section unless the insurer complies  
11 with the following requirements:

12       (a) The insurer provides an actuarial memorandum, in a form  
13 and manner prescribed by the commissioner, describing the manner  
14 in which the revised rating methodology and resultant rates  
15 differ from the existing methodology and existing rates.

16       (b) The insurer does not subsequently put into effect a  
17 change of rates or rating factors that would cause the percentage  
18 differential between the discontinued and subsequent rates as  
19 described in the actuarial memorandum to change. The commissioner  
20 may approve a change to the differential that is in the public  
21 interest.

22       **(10)** ~~—(9)—~~ The experience of all medicare supplement policy  
23 forms or certificate forms of the same type in a standard  
24 medicare supplement benefit plan shall be combined for purposes  
25 of the refund or credit calculation prescribed in section 3853  
26 except that forms assumed under an assumption reinsurance  
27 agreement shall not be combined with the experience of other

1 forms for purposes of the refund or credit calculation.

2       **(11)** ~~—(10)—~~ Each insurer that issues medicare supplement  
3 policies for delivery in this state shall comply with sections  
4 1842 and 1882 of title XVIII of the social security act, ~~—chapter~~  
5 ~~531, 49 Stat. 620, 42 U.S.C.~~ **USC** 1395u and 1395ss, and shall  
6 certify that compliance on the medicare supplement insurance  
7 experience reporting form.

8       **(12)** ~~—(11)—~~ For the purposes of this section, "type" means  
9 an individual policy, a group policy, an individual medicare  
10 select policy, or a group medicare select policy.

11       Enacting section 1. Sections 451 to 499a of the nonprofit  
12 health care corporation reform act, 1980 PA 350, MCL 550.1451 to  
13 550.1499a, are repealed.