HOUSE SUBSTITUTE FOR

SENATE BILL NO. 748

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending the title and sections 3515, 3519, 3523, 3529, 3801, 3807, 3809, 3811, 3815, 3819, and 3829 (MCL 500.3515, 500.3519, 500.3523, 500.3529, 500.3801, 500.3807, 500.3809, 500.3811, 500.3815, 500.3819, and 500.3829), the title as amended by 1998 PA 457, sections 3515, 3519, 3523, and 3529 as added by 2000 PA 252, and sections 3801, 3807, 3809, 3811, 3815, 3819, and 3829 as added by 1992 PA 84, and by adding sections 224b, 3830, and 3830a; and to repeal acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

TITLE

An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety

companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to provide for the imposition of regulatory fees on certain insurers; TO PROVIDE FOR ASSESSMENT FEES ON CERTAIN HEALTH MAINTENANCE ORGANIZATIONS; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured

persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for regulation over worker's compensation self-insurers; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; TO PROVIDE FOR AN APPROPRIATION; to repeal acts and parts of acts; and to provide penalties for the violation of this act.

SEC. 224B. (1) THE DEPARTMENT OF COMMUNITY HEALTH SHALL ASSESS ON EACH HEALTH MAINTENANCE ORGANIZATION THAT HAS A MEDICAID MANAGED CARE CONTRACT AWARDED BY THE STATE AND ADMINISTRATED BY THE DEPARTMENT OF COMMUNITY HEALTH A QUALITY ASSURANCE ASSESSMENT FEE THAT EQUALS A PERCENTAGE ESTABLISHED BY THE

DEPARTMENT OF COMMUNITY HEALTH THAT, WHEN APPLIED TO EACH HEALTH MAINTENANCE ORGANIZATION'S NON-MEDICARE PREMIUMS PAID TO THE HEALTH MAINTENANCE ORGANIZATION, TOTALS AN AMOUNT THAT WOULD EQUAL A 5% INCREASE FOR THE MEDICAID MANAGED CARE PROGRAM NET OF THE VALUE OF THE QUALITY ASSURANCE ASSESSMENT FEE.

(2) THE QUALITY ASSURANCE ASSESSMENT FEE COLLECTED UNDER SUBSECTION (1) AND ALL FEDERAL MATCHING FUNDS ATTRIBUTED TO THAT FEE SHALL BE USED FOR THE FOLLOWING PURPOSES AND UNDER THE FOLLOWING SPECIFIC CIRCUMSTANCES:

(A) THE ENTIRE QUALITY ASSURANCE ASSESSMENT FEE AND ALL FEDERAL MATCHING FUNDS ATTRIBUTED TO THAT FEE SHALL BE USED TO MAINTAIN THE MEDICAID REIMBURSEMENT RATE INCREASE IN EACH FISCAL YEAR IN WHICH THE FEE IS FIRST ASSESSED. ONLY A HEALTH MAINTENANCE ORGANIZATION THAT IS ASSESSED THE QUALITY ASSURANCE ASSESSMENT FEE IS ELIGIBLE FOR THE INCREASED MEDICAID REIMBURSEMENT RATES UNDER THIS SECTION.

(B) THE QUALITY ASSURANCE ASSESSMENT FEE SHALL BE IMPLEMENTED ON THE EFFECTIVE DATE OF THE AMENDATORY ACT THAT ADDED THIS SECTION.

(C) THE QUALITY ASSURANCE ASSESSMENT FEE SHALL BE ASSESSED ON THE NON-MEDICARE PREMIUMS COLLECTED BY EACH HEALTH MAINTENANCE ORGANIZATION DESCRIBED IN SUBSECTION (1) IN CALENDAR YEAR 2001. IF THE HEALTH MAINTENANCE ORGANIZATION DID NOT HAVE NON-MEDICARE PREMIUM REVENUE IN CALENDAR YEAR 2001, THE ASSESSMENT SHALL BE BASED ON THE HEALTH MAINTENANCE ORGANIZATION'S NON-MEDICARE PREMIUMS COLLECTED IN THE IMMEDIATELY PRECEDING QUARTER. EXCEPT AS OTHERWISE PROVIDED, THE QUALITY ASSURANCE ASSESSMENT FEE SHALL BE

PAYABLE ON A QUARTERLY BASIS WITH THE FIRST PAYMENT DUE 90 DAYS AFTER THE DATE THE FEE IS ASSESSED. HOWEVER, FOR A HEALTH MAINTENANCE ORGANIZATION THAT DID NOT HAVE NON-MEDICARE PREMIUM REVENUE IN CALENDAR YEAR 2001, THE FIRST QUALITY ASSURANCE ASSESSMENT FEE SHALL BE ASSESSED AS SOON AS POSSIBLE AND SHALL BE PAYABLE UPON RECEIPT.

(D) THE QUALITY ASSURANCE ASSESSMENT FEE SHALL ONLY BE ASSESSED ON A HEALTH MAINTENANCE ORGANIZATION THAT HAS IN EFFECT A MEDICAID MANAGED CARE CONTRACT AWARDED BY THE STATE AND ADMINISTERED BY THE DEPARTMENT OF COMMUNITY HEALTH AT THE TIME OF THE ASSESSMENT.

(E) BEGINNING OCTOBER 1, 2003, THE QUALITY ASSURANCE ASSESSMENT FEE SHALL NO LONGER BE ASSESSED OR COLLECTED.

(F) THE DEPARTMENT OF COMMUNITY HEALTH SHALL IMPLEMENT THIS SECTION IN A MANNER THAT COMPLIES WITH FEDERAL REQUIREMENTS NECESSARY TO ASSURE THAT THE QUALITY ASSURANCE ASSESSMENT FEE QUALIFIES FOR FEDERAL MATCHING FUNDS. IF THE DEPARTMENT OF COMMUNITY HEALTH IS UNABLE TO COMPLY WITH THE FEDERAL REQUIREMENTS FOR FEDERAL MATCHING FUNDS UNDER THIS SECTION OR IS UNABLE TO USE THE FISCAL YEAR 2001-2002 LEVEL OF SUPPORT FOR FEDERAL MATCHING DOLLARS OTHER THAN FOR A CHANGE IN COVERED BENEFITS OR COVERED POPULATION REQUIRED UNDER THE STATE'S MEDICAID CONTRACT WITH HEALTH MAINTENANCE ORGANIZATIONS, THE QUALITY ASSURANCE ASSESSMENT FEE UNDER THIS SECTION SHALL NO LONGER BE ASSESSED OR COLLECTED.

(G) IF A HEALTH MAINTENANCE ORGANIZATION FAILS TO PAY THE QUALITY ASSURANCE ASSESSMENT FEE REQUIRED UNDER SUBSECTION (1), THE DEPARTMENT OF COMMUNITY HEALTH MAY ASSESS THE HEALTH

MAINTENANCE ORGANIZATION A PENALTY OF 5% OF THE ASSESSMENT FOR EACH MONTH THAT THE ASSESSMENT AND PENALTY ARE NOT PAID UP TO A MAXIMUM OF 50% OF THE ASSESSMENT. THE DEPARTMENT OF COMMUNITY HEALTH MAY ALSO REFER FOR COLLECTION TO THE DEPARTMENT OF TREASURY PAST DUE AMOUNTS CONSISTENT WITH SECTION 13 OF 1941 PA 122, MCL 205.13.

(H) THE MEDICAID HEALTH MAINTENANCE ORGANIZATION QUALITY ASSURANCE ASSESSMENT FUND IS ESTABLISHED AS A SEPARATE FUND IN THE STATE TREASURY. THE DEPARTMENT OF COMMUNITY HEALTH SHALL DEPOSIT THE REVENUE RAISED THROUGH THE QUALITY ASSURANCE ASSESSMENT FEE WITH THE STATE TREASURER FOR DEPOSIT IN THE MEDICAID HEALTH MAINTENANCE ORGANIZATION QUALITY ASSURANCE ASSESSMENT FUND TO BE USED AS PROVIDED IN SUBSECTION (2)(A).

(I) IN ALL FISCAL YEARS GOVERNED BY THIS SECTION, MEDICAID REIMBURSEMENT RATES SHALL NOT BE REDUCED BELOW THE MEDICAID PAYMENT RATES IN EFFECT ON APRIL 1, 2002 AS A DIRECT RESULT OF THE QUALITY ASSURANCE ASSESSMENT FEE ASSESSED UNDER THIS SECTION. THIS SUBDIVISION DOES NOT APPLY TO A CHANGE IN MEDICAID REIMBURSEMENT RATES CAUSED BY A CHANGE IN COVERED BENEFITS OR CHANGE IN COVERED POPULATIONS REQUIRED UNDER THE STATE'S MEDICAID CONTRACT WITH HEALTH MAINTENANCE ORGANIZATIONS.

(J) THE AMOUNTS LISTED IN THIS SUBDIVISION ARE APPROPRIATED FOR THE DEPARTMENT OF COMMUNITY HEALTH, SUBJECT TO THE CONDITIONS SET FORTH IN THIS SECTION, FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 2003:

MEDICAL SERVICES

HEALTH PLAN SERVICES..... $ 1,476,781,100

GROSS APPROPRIATION..... $ 1,476,781,100

APPROPRIATED FROM:

FEDERAL REVENUES:

TOTAL FEDERAL REVENUES..... 817,495,900

SPECIAL REVENUE FUNDS:

MEDICAID QUALITY ASSURANCE ASSESSMENT..... 55,747,000

STATE GENERAL FUND/GENERAL PURPOSE..... $ 603,538,200

(3) AS USED IN THIS SECTION:

(A) "MEDICAID" MEANS TITLE XIX OF THE SOCIAL SECURITY ACT, CHAPTER 531, 49 STAT. 620, 42 U.S.C. 1396 TO 1396r-6 AND 1396r-8 TO 1396v.

(B) "MEDICARE" MEANS TITLE XVIII OF THE SOCIAL SECURITY ACT, CHAPTER 531, 49 STAT. 620, 42 U.S.C. 1395 TO 1395b, 1395b-2, 1395b-6 TO 1395b-7, 1395c TO 1395i, 1395i-2 TO 1395i-5, 1395j TO 1395t, 1395u TO 1395w, 1395w-2 TO 1395w-4, 1395w-21 TO 1395w-28, 1395x TO 1395yy, AND 1395bbb TO 1395ggg.

Sec. 3515. (1) A health maintenance organization may provide additional health maintenance services or any other related health care service or treatment not required under this chapter.

(2) A health maintenance organization may have health maintenance contracts with DEDUCTIBLES. A HEALTH MAINTENANCE ORGANIZATION MAY HAVE HEALTH MAINTENANCE CONTRACTS WITH nominal copayments that are required for specific health maintenance services. Copayments, EXCLUDING DEDUCTIBLES, shall not exceed 50% of a health maintenance organization's reimbursement to an

affiliated provider for providing the service to an enrollee and shall not be based on the provider's standard charge for the service. [A HEALTH MAINTENANCE ORGANIZATION SHALL NOT REQUIRE CONTRIBUTIONS BE MADE TO A DEDUCTIBLE FOR PREVENTATIVE HEALTH CARE SERVICES. AS USED IN THIS SUBSECTION, "PREVENTATIVE HEALTH CARE SERVICES" MEANS SERVICES DESIGNATED TO MAINTAIN AN INDIVIDUAL IN OPTIMUM HEALTH AND TO PREVENT UNNECESSARY INJURY, ILLNESS, OR DISABILITY.]

(3) A health maintenance organization may accept from governmental agencies and from private persons payments covering any part of the cost of health maintenance contracts.

Sec. 3519. (1) A health maintenance organization contract and the contract's rates, including any DEDUCTIBLES AND nominal copayments, between the organization and its subscribers shall be fair, sound, and reasonable in relation to the services provided, and the procedures for offering and terminating contracts shall not be unfairly discriminatory.

(2) A health maintenance organization contract and the contract's rates shall not discriminate on the basis of race, color, creed, national origin, residence within the approved service area of the health maintenance organization, lawful occupation, sex, handicap, or marital status, except that marital status may be used to classify individuals or risks for the purpose of insuring family units. The commissioner may approve a rate differential based on sex, age, residence, disability, marital status, or lawful occupation, if the differential is supported by sound actuarial principles, a reasonable classification system, and is related to the actual and credible loss statistics or reasonably anticipated experience for new coverages.

(3) All health maintenance organization contracts shall include, at a minimum, basic health services.

Sec. 3523. (1) A health maintenance contract shall be filed with and approved by the commissioner.

(2) A health maintenance contract shall include any approved riders, amendments, and the enrollment application.

(3) In addition to the provisions of this act that apply to an expense-incurred hospital, medical, or surgical policy or certificate, a health maintenance contract shall include all of the following:

(a) Name and address of the organization.

(b) Definitions of terms subject to interpretation.

(c) The effective date and duration of coverage.

(d) The conditions of eligibility.

(e) A statement of responsibility for payments.

(f) A description of specific benefits and services available under the contract within the service area, with respective copayments AND DEDUCTIBLES.

(g) A description of emergency and out-of-area services.

(h) A specific description of any limitation, exclusion, and exception, including any preexisting condition limitation, grouped together with captions in boldfaced type.

(i) Covenants ~~which~~ THAT address confidentiality, an enrollee's right to choose or change the primary care physician or other providers, availability and accessibility of services, and any rights of the enrollee to inspect and review his or her medical records.

(j) Covenants of the subscriber shall address all of the following subjects:

(*i*) Timely payment.

(*ii*) Nonassignment of benefits.

(*iii*) Truth in application and statements.

(*iv*) Notification of change in address.

(*v*) Theft of membership identification.

(k) A statement of responsibilities and rights regarding the grievance procedure.

(*l*) A statement regarding subrogation and coordination of benefits provisions, including any responsibility of the enrollee to cooperate.

(m) A statement regarding conversion rights.

(n) Provisions for adding new family members or other acquired dependents, including conversion of individual contracts to family contracts and family contracts to individual contracts, and the time constraints imposed.

(o) Provisions for grace periods for late payment.

(p) A description of any specific terms under which the health maintenance organization or the subscriber can terminate the contract.

(q) A statement of the nonassignability of the contract.

Sec. 3529. (1) A health maintenance organization may contract with or employ health professionals on the basis of cost, quality, availability of services to the membership, conformity to the administrative procedures of the health maintenance organization, and other factors relevant to delivery of economical, quality care, but shall not discriminate solely on the basis of

the class of health professionals to which the health professional belongs.

(2) A health maintenance organization shall enter into contracts with providers through which health care services are usually provided to enrollees under the health maintenance organization plan.

(3) An affiliated provider contract shall prohibit the provider from seeking payment from the enrollee for services provided pursuant to the provider contract, except that the contract may allow affiliated providers to collect copayments AND DEDUCTIBLES directly from enrollees.

(4) An affiliated provider contract shall contain provisions assuring all of the following:

(a) The provider meets applicable licensure or certification requirements.

(b) Appropriate access by the health maintenance organization to records or reports concerning services to its enrollees.

(c) The provider cooperates with the health maintenance organization's quality assurance activities.

(5) The commissioner may waive the contract requirement under subsection (2) if a health maintenance organization has demonstrated that it is unable to obtain a contract and accessibility to patient care would not be compromised. When 10% or more of a health maintenance organization's elective inpatient admissions, or projected admissions for a new health maintenance organization, occur in hospitals with which the health maintenance organization does not have contracts or agreements

that protect enrollees from liability for authorized admissions and services, the health maintenance organization may be required to maintain a hospital reserve fund equal to 3 months' projected claims from such hospitals.

(6) A health maintenance organization shall submit to the commissioner for approval standard contract formats proposed for use with its affiliated providers and any substantive changes to those contracts. The contract format or change is considered approved 30 days after filing unless approved or disapproved within the 30 days. As used in this subsection, "substantive changes to contract formats" means a change to a provider contract that alters the method of payment to a provider, alters the risk assumed by each party to the contract, or affects a provision required by law.

(7) A health maintenance organization or applicant shall provide evidence that it has employed, or has executed affiliation contracts with, a sufficient number of providers to enable it to deliver the health maintenance services it proposes to offer.

Sec. 3801. As used in this chapter:

(a) "Applicant" means:

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

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

(B) "BANKRUPTCY" MEANS WHEN A MEDICARE+CHOICE ORGANIZATION THAT IS NOT AN INSURER HAS FILED, OR HAS HAD FILED AGAINST IT, A

PETITION FOR DECLARATION OF BANKRUPTCY AND HAS CEASED DOING BUSINESS IN THIS STATE.

(C) ~~(b)~~ "Certificate" means any certificate delivered or issued for delivery in this state under a group medicare supplement policy.

(D) ~~(c)~~ "Certificate form" means the form on which the certificate is delivered or issued for delivery by the insurer.

(E) "CONTINUOUS PERIOD OF CREDITABLE COVERAGE" MEANS THE PERIOD DURING WHICH AN INDIVIDUAL WAS COVERED BY CREDITABLE COVERAGE, IF DURING THE PERIOD OF THE COVERAGE THE INDIVIDUAL HAD NO BREAKS IN COVERAGE GREATER THAN 63 DAYS.

(F) "CREDITABLE COVERAGE" MEANS COVERAGE OF AN INDIVIDUAL PROVIDED UNDER ANY OF THE FOLLOWING:

(*i*) A GROUP HEALTH PLAN.

(*ii*) HEALTH INSURANCE COVERAGE.

(*iii*) PART A OR PART B OF MEDICARE.

(*iv*) MEDICAID OTHER THAN COVERAGE CONSISTING SOLELY OF BENEFITS UNDER SECTION 1928 OF MEDICAID, 42 U.S.C. 1396s.

(*v*) CHAPTER 55 OF TITLE 10 OF THE UNITED STATES CODE, 10 U.S.C. 1071 TO 1110.

(*vi*) A MEDICAL CARE PROGRAM OF THE INDIAN HEALTH SERVICE OR OF A TRIBAL ORGANIZATION.

(*vii*) A STATE HEALTH BENEFITS RISK POOL.

(*viii*) A HEALTH PLAN OFFERED UNDER CHAPTER 89 OF TITLE 5 OF THE UNITED STATES CODE, 5 U.S.C. 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. 2504.

(G) ~~(d)~~ "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. 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, DELIVERING OR ISSUING FOR DELIVERY IN THIS STATE MEDICARE SUPPLEMENT POLICIES.

(K) ~~(e)~~ "Medicaid" means ~~title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396f, and 1396i to 1396u~~ TITLE XIX OF THE SOCIAL SECURITY ACT, CHAPTER 531, 49 STAT. 620, 42 U.S.C. 1396 TO 1396r-6 AND 1396r-8 TO 1396v.

(*l*) ~~(f)~~ "Medicare" means title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, ~~1395c to 1395i, 1395i-2 to 1395i-4, 1395j to 1395t,~~

~~1395u to 1395w-2, 1395w-4 to 1395zz, and 1395bbb to 1395ccc~~ 1395b-6 TO 1395b-7, 1395c TO 1395i, 1395i-2 TO 1395i-5, 1395j TO 1395t, 1395u TO 1395w, 1395w-2 TO 1395w-4, 1395w-21 TO 1395w-28, 1395x TO 1395yy, AND 1395bbb TO 1395ggg.

(M) "MEDICARE+CHOICE PLAN" MEANS A PLAN OF COVERAGE FOR HEALTH BENEFITS UNDER MEDICARE PART C AS DEFINED IN SECTION 12-2859 OF PART C OF MEDICARE, 42 U.S.C. 1395w-28, AND INCLUDES ANY OF THE FOLLOWING:

(*i*) COORDINATED CARE PLANS THAT PROVIDE HEALTH CARE SERVICES, INCLUDING, BUT NOT LIMITED TO, HEALTH MAINTENANCE ORGANIZATION PLANS WITH OR WITHOUT A POINT-OF-SERVICE OPTION, PLANS OFFERED BY PROVIDER-SPONSORED ORGANIZATIONS, AND PREFERRED PROVIDER ORGANIZATION PLANS.

(*ii*) MEDICAL SAVINGS ACCOUNT PLANS COUPLED WITH A CONTRIBUTION INTO A MEDICARE+CHOICE MEDICAL SAVINGS ACCOUNT.

(*iii*) MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS.

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

(O) ~~(h)~~ "Medicare supplement policy" means an individual or group policy or certificate of insurance that is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare and medicare select policies and

certificates under section 3817. Medicare supplement policy does not include a policy or contract of 1 or more employers or labor organizations, or of the trustees of a fund established by 1 or more employers or labor organizations, or both, for employees or former employees, or both, or for members or former members, or both, of the labor organizations.

(P) "PACE" MEANS A PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY AS DESCRIBED IN THE SOCIAL SECURITY ACT.

(Q) ~~(i)~~ "Policy form" means the form on which the policy is delivered or issued for delivery by the insurer.

(R) "SECRETARY" MEANS THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(S) "SOCIAL SECURITY ACT" MEANS THE SOCIAL SECURITY ACT, CHAPTER 531, 49 STAT. 620.

Sec. 3807. Every insurer issuing a medicare supplement insurance policy in this state shall make available a medicare supplement insurance policy that includes a basic core package of benefits to each prospective insured. An insurer issuing a medicare supplement insurance policy in this state may make available to prospective insureds benefits pursuant to section 3809 that are in addition to, but not instead of, the basic core package. The basic core package of benefits shall include all of the following:

(a) Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the 61st day through the 90th day in any medicare benefit period.

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

(c) Upon exhaustion of the medicare hospital inpatient coverage including the lifetime reserve days, coverage of the medicare part A eligible expenses for hospitalization paid at the diagnostic related group day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

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

(e) Coverage for the coinsurance amount, OR THE COPAYMENT AMOUNT PAID FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES UNDER A PROSPECTIVE PAYMENT SYSTEM, of medicare eligible expenses under part B regardless of hospital confinement, subject to the medicare part B deductible.

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

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

(b) Skilled nursing facility care: coverage for the actual billed charges up to the coinsurance amount from the 21st day

through the 100th day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare part A.

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

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

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

(f) Basic outpatient prescription drug benefit: coverage for 50% of outpatient prescription drug charges, after a $250.00 calendar year deductible, to a maximum of $1,250.00 in benefits received by the insured per calendar year, to the extent not covered by medicare.

(g) Extended outpatient prescription drug benefit: coverage for 50% of outpatient prescription drug charges, after a $250.00 calendar year deductible, to a maximum of $3,000.00 in benefits received by the insured per calendar year, to the extent not covered by medicare.

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

(i) Preventive medical care benefit: Coverage for the following preventive health services:

(*i*) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (*ii*) and patient education to address preventive health care measures.

(*ii*) Any 1 or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) ~~Fecal occult blood test and digital~~ DIGITAL rectal examination.

~~(B) Mammogram.~~

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

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

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

(E) ~~(F)~~ Thyroid function test.

(F) ~~(G)~~ Diabetes screening.

(G) ~~(H) Influenza vaccine administered at any appropriate time during the year and tetanus~~ TETANUS and diphtheria booster every 10 years.

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

(j) At-home recovery benefit: coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery. At-home recovery services provided shall be primarily services that assist in activities of daily living. The 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 new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. These benefits may include benefits that are appropriate to medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of medicare supplement policies.

(2) Reimbursement for the preventive screening tests and services under subsection (1)(i)(*ii*) shall be for the actual charges up to 100% of the medicare-approved amount for each test or service, as if medicare were to cover the test or service as

identified in the American medical association current procedural terminology codes, to a maximum of $120.00 annually under this benefit. This benefit shall not include payment for any procedure covered by medicare.

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

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

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

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

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

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

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

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

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

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

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

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

(c) A standardized medicare supplement benefit plan C 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, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (c), and (h).

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

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

(f) A standardized medicare supplement benefit plan F shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (c), (e), and (h). A STANDARDIZED MEDICARE SUPPLEMENT PLAN F HIGH DEDUCTIBLE SHALL INCLUDE ONLY THE FOLLOWING: 100% OF COVERED EXPENSES FOLLOWING THE PAYMENT OF THE ANNUAL HIGH DEDUCTIBLE PLAN F DEDUCTIBLE. THE COVERED EXPENSES INCLUDE THE CORE BENEFITS AS DEFINED IN SECTION 3807, PLUS THE MEDICARE PART A DEDUCTIBLE, SKILLED NURSING FACILITY CARE, THE MEDICARE PART B DEDUCTIBLE,

100% OF THE MEDICARE PART B EXCESS CHARGES, AND MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY AS DEFINED IN SECTION 3809(1)(A), (B), (C), (E), AND (H). THE ANNUAL HIGH DEDUCTIBLE PLAN F DEDUCTIBLE SHALL CONSIST OF OUT-OF-POCKET EXPENSES, OTHER THAN PREMIUMS, FOR SERVICES COVERED BY THE MEDICARE SUPPLEMENT PLAN F POLICY, AND SHALL BE IN ADDITION TO ANY OTHER SPECIFIC BENEFIT DEDUCTIBLES. THE ANNUAL HIGH DEDUCTIBLE PLAN F DEDUCTIBLE IS $1,580.00 FOR CALENDAR YEAR 2001, AND THE SECRETARY SHALL ADJUST IT ANNUALLY THEREAFTER TO REFLECT THE CHANGE IN THE CONSUMER PRICE INDEX FOR ALL URBAN CONSUMERS FOR THE 12-MONTH PERIOD ENDING WITH AUGUST OF THE PRECEDING YEAR, ROUNDED TO THE NEAREST MULTIPLE OF $10.00.

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

(h) A standardized medicare supplement benefit plan H shall include only the following: the core benefits as defined in section 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).

(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).

(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 EXPENSES FOLLOWING THE PAYMENT OF THE ANNUAL HIGH DEDUCTIBLE PLAN J DEDUCTIBLE. THE COVERED EXPENSES INCLUDE THE CORE BENEFITS AS DEFINED IN SECTION 3807, PLUS 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 BENEFIT AND AT-HOME RECOVERY BENEFIT AS DEFINED IN SECTION 3809(1)(A), (B), (C), (E), (G), (H), (I), AND (J). THE ANNUAL HIGH DEDUCTIBLE PLAN J DEDUCTIBLE SHALL CONSIST OF OUT-OF-POCKET EXPENSES, OTHER THAN PREMIUMS, FOR SERVICES COVERED BY THE MEDICARE SUPPLEMENT PLAN J POLICY, AND SHALL BE IN ADDITION TO ANY OTHER SPECIFIC BENEFIT

DEDUCTIBLES. THE ANNUAL DEDUCTIBLE SHALL BE $1,580.00 FOR CALENDAR YEAR 2001, AND THE SECRETARY SHALL ADJUST IT ANNUALLY THEREAFTER TO REFLECT THE CHANGE IN THE CONSUMER PRICE INDEX FOR ALL URBAN CONSUMERS FOR THE 12-MONTH PERIOD ENDING WITH AUGUST OF THE PRECEDING YEAR, ROUNDED TO THE NEAREST MULTIPLE OF $10.00.

Sec. 3815. (1) An insurer that offers a medicare supplement policy shall provide to the applicant at the time of application an outline of coverage and, except for direct response 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) 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.

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

(Insurer Name)
Medicare Supplement Coverage
Outline of Medicare Supplement Coverage-Cover Page:
Benefit Plan(s)_____ [insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only 10 standard plans PLUS 2 HIGH DEDUCTIBLE PLANS. This chart shows the benefits included in each plan. Every insurer shall make available Plan "A". Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.

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

Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses) OR, FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES UNDER A PROSPECTIVE PAYMENT SYSTEM, APPLICABLE COPAYMENTS.

Blood: First three pints of blood each year.

	A	B	C	D	E	F	G	H	I	J
Basic Benefits	x	x	x	x	x	x	x	x	x	x
Skilled Nursing Co-Insurance			x	x	x	x	x	x	x	x
Part A Deductible		x	x	x	x	x	x	x	x	x
Part B Deductible			x			x				x
Part B Excess						x 100%	x 80%		x 100%	x 100%
Foreign Travel Emergency			x	x	x	x	x	x	x	x
At-Home Recovery				x			x		x	x
Drugs								x $1,250 Limit	x $1,250 Limit	x $3,000 Limit
Preventive Care					X					x

PREMIUM INFORMATION

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

DISCLOSURES

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

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

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

[For agent issued policies]

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

[For direct response issued policies]

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$628~~ $792	$0	~~$628~~ $792 (Part A Deductible)
61st thru 90th day	All but ~~$157~~ $198 a day	~~$157~~ $198 a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but ~~$314~~ $396 a day	~~$314~~ $396 a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$78.50~~ $99 a day	$0	Up to ~~$78.50~~ $99 a day
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN A

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

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

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

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services --Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$628~~ $792	~~$628~~ $792 (Part A Deductible)	$0
61st thru 90th day	All but ~~$157~~ $198 a day	~~$157~~ $198 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but ~~$314~~ $396 a day	~~$314~~ $396 a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$78.50~~ $99 a day	$0	Up to ~~$78.50~~ $99 a day
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN B

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

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

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

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$628~~ $792	~~$628~~ $792 (Part A Deductible)	$0
61st thru 90th day	All but ~~$157~~ $198 a day	~~$157~~ $198 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but ~~$314~~ $396 a day	~~$314~~ $396 a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$78.50~~ $99 a day	Up to ~~$78.50~~ $99 a day	$0
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN C

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

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

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

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services --Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL-- Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$628~~ $792	~~$628~~ $792 (Part A Deductible)	$0
61st thru 90th day	All but ~~$157~~ $198 a day	~~$157~~ $198 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but ~~$314~~ $396 a day	~~$314~~ $396 a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$78.50~~ $99 a day	Up to ~~$78.50~~ $99 a day	$0
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN D

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

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

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

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services --Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-- Not covered by Medicare Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan --Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	$0	$1,600	

(continued)

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL-- Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$628~~ $792	~~$628~~ $792 (Part A Deductible)	$0
61st thru 90th day	All but ~~$157~~ $198 a day	~~$157~~ $198 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but ~~$314~~ $396 a day	~~$314~~ $396 a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$78.50~~ $99 a day	Up to ~~$78.50~~ $99 a day	$0
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN E

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

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

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

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL-- Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT-- Not covered by Medicare Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education,			

administered or ordered			
by your doctor when not			
covered by Medicare			
First $120 each			
calendar year	$0	$120	$0
Additional charges	$0	$0	All Costs

PLAN F OR HIGH DEDUCTIBLE PLAN F

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

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

**THIS HIGH DEDUCTIBLE PLAN PAYS THE SAME OR OFFERS THE SAME BENEFITS AS PLAN F AFTER YOU HAVE PAID A CALENDAR YEAR ($1,580) DEDUCTIBLE. BENEFITS FROM THE HIGH DEDUCTIBLE PLAN F WILL NOT BEGIN UNTIL OUT-OF-POCKET EXPENSES ARE $1,580. OUT-OF-POCKET EXPENSES FOR THIS DEDUCTIBLE ARE EXPENSES THAT WOULD ORDINARILY BE PAID BY THE POLICY. THIS INCLUDES MEDICARE DEDUCTIBLES FOR PART A AND PART B, BUT DOES NOT INCLUDE THE PLAN'S SEPARATE FOREIGN TRAVEL EMERGENCY DEDUCTIBLE.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,580 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $1,580 DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$628~~ $792	~~$628~~ $792 (Part A Deductible)	$0
61st thru 90th day	All but ~~$157~~ $198 a day	~~$157~~ $198 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but ~~$314~~ $396 a day	~~$314~~ $396 a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and			

entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$78.50~~ $99 a day	Up to ~~$78.50~~ $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN F

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

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

**THIS HIGH DEDUCTIBLE PLAN PAYS THE SAME OR OFFERS THE SAME BENEFITS AS PLAN F AFTER YOU HAVE PAID A CALENDAR YEAR ($1,580) DEDUCTIBLE. BENEFITS FROM THE HIGH DEDUCTIBLE PLAN F WILL NOT BEGIN UNTIL OUT-OF-POCKET EXPENSES ARE $1,580. OUT-OF-POCKET EXPENSES FOR THIS DEDUCTIBLE ARE EXPENSES THAT WOULD ORDINARILY BE PAID BY THE POLICY. THIS INCLUDES MEDICARE DEDUCTIBLES FOR PART A AND PART B, BUT DOES NOT INCLUDE THE PLAN'S SEPARATE FOREIGN TRAVEL EMERGENCY DEDUCTIBLE.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,580 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $1,580 DEDUCTIBLE**, YOU PAY
MEDICAL EXPENSES-- In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

CLINICAL LABORATORY SERVICES-- Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services --Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL-- Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$628~~ $792	~~$628~~ $792 (Part A Deductible)	$0
61st thru 90th day	All but ~~$157~~ $198 a day	~~$157~~ $198 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but ~~$314~~ $396 a day	~~$314~~ $396 a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$78.50~~ $99 a day	Up to ~~$78.50~~ $99 a day	$0
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN G

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

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

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

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services --Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-- Not covered by Medicare Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan --Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	$0	$1,600	

(continued)

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL-- Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN H

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$628~~ $792	~~$628~~ $792 (Part A Deductible)	$0
61st thru 90th day	All but ~~$157~~ $198 a day	~~$157~~ $198 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but ~~$314~~ $396 a day	~~$314~~ $396 a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$78.50~~ $99 a day	Up to ~~$78.50~~ $99 a day	$0
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN H

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

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

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

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services --Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL-- Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS-- Not covered by Medicare			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%--$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

PLAN I

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$628~~ $792	~~$628~~ $792 (Part A Deductible)	$0
61st thru 90th day	All but ~~$157~~ $198 a day	~~$157~~ $198 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but ~~$314~~ $396 a day	~~$314~~ $396 a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$78.50~~ $99 a day	Up to ~~$78.50~~ $99 a day	$0
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN I

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

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

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

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services --Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-- Not covered by Medicare Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			Balance
--Benefit for each visit	$0	Actual Charges to $40 a visit	
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	$0	$1,600	

(continued)

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL-- Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges*	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS-- Not covered by Medicare			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%--$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

PLAN J OR HIGH DEDUCTIBLE PLAN J
MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

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

**THIS HIGH DEDUCTIBLE PLAN PAYS THE SAME OR OFFERS THE SAME BENEFITS AS PLAN J AFTER YOU HAVE PAID A CALENDAR YEAR ($1,580) DEDUCTIBLE. BENEFITS FROM THE HIGH DEDUCTIBLE PLAN J WILL NOT BEGIN UNTIL OUT-OF-POCKET EXPENSES ARE $1,580. OUT-OF-POCKET EXPENSES FOR THIS DEDUCTIBLE ARE EXPENSES THAT WOULD ORDINARILY BE PAID BY THE POLICY. THIS INCLUDES MEDICARE DEDUCTIBLES FOR PART A AND PART B, BUT DOES NOT INCLUDE THE PLAN'S SEPARATE FOREIGN TRAVEL EMERGENCY DEDUCTIBLE.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,580 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $1,580 DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$628~~ $792	~~$628~~ $792 (Part A Deductible)	$0
61st thru 90th day	All but ~~$157~~ $198 a day	~~$157~~ $198 a day	$0
91st day and after			
--While using 60 lifetime reserve days	All but ~~$314~~ $396 a day	~~$314~~ $396 a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and			

entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$78.50~~ $99 a day	Up to ~~$78.50~~ $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN J

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

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

**THIS HIGH DEDUCTIBLE PLAN PAYS THE SAME OR OFFERS THE SAME BENEFITS AS PLAN J AFTER YOU HAVE PAID A CALENDAR YEAR ($1,580) DEDUCTIBLE. BENEFITS FROM THE HIGH DEDUCTIBLE PLAN J WILL NOT BEGIN UNTIL OUT-OF-POCKET EXPENSES ARE $1,580. OUT-OF-POCKET EXPENSES FOR THIS DEDUCTIBLE ARE EXPENSES THAT WOULD ORDINARILY BE PAID BY THE POLICY. THIS INCLUDES MEDICARE DEDUCTIBLES FOR PART A AND PART B, BUT DOES NOT INCLUDE THE PLAN'S SEPARATE FOREIGN TRAVEL EMERGENCY DEDUCTIBLE.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,580 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $1,580 DEDUCTIBLE**, YOU PAY
MEDICAL EXPENSES-- In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

CLINICAL LABORATORY SERVICES-- Blood tests for diagnostic services	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE Medicare Approved Services			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-- Not covered by Medicare			
Home care certified by your doctor, for personal care beginning during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	$0	$1,600	

(continued)

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL-- Not covered by Medicare gency care services begin- ning during the first 60 days of each trip outside the USA			
First $250 each calen- dar year	$0	$0	$250
Remainder of Charges	$0	80% to a life- time maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRE- SCRIPTION DRUGS-- Not covered by Medicare			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50%--$3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All Costs
PREVENTIVE MEDICAL CARE BENEFIT-- Not covered by Medicare Annual physical and pre- ventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid func- tion test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

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

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

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

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

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

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

(e) Termination of a medicare supplement policy shall not reduce or limit the payment of benefits for any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

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

(3) A medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder or certificate holder for a period not to exceed 24 months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under medicaid, but only if the policyholder or certificate holder notifies the insurer of such assistance within 90 days after the date the individual becomes entitled to the assistance. Upon receipt of timely notice, the insurer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of medicaid eligibility, subject to adjustment for paid claims. If a suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance under medicaid, the policy shall be automatically reinstituted effective as of the date of termination of the assistance if the policyholder or certificate holder provides

notice of loss of medicaid medical assistance within 90 days after the date of the loss and pays the premium attributable to the period effective as of the date of termination of the assistance. EACH MEDICARE SUPPLEMENT POLICY SHALL PROVIDE THAT BENEFITS AND PREMIUMS UNDER THE POLICY SHALL BE SUSPENDED AT THE REQUEST OF THE POLICYHOLDER IF THE POLICYHOLDER IS ENTITLED TO BENEFITS UNDER SECTION 226(B) OF TITLE II OF THE SOCIAL SECURITY ACT, AND IS COVERED UNDER A GROUP HEALTH PLAN AS DEFINED IN SECTION 1862(B)(1)(A)(*v*) OF THE SOCIAL SECURITY ACT. IF SUSPENSION OCCURS AND IF THE POLICYHOLDER OR CERTIFICATE HOLDER LOSES COVERAGE UNDER THE GROUP HEALTH PLAN, THE POLICY SHALL BE AUTOMATICALLY REINSTITUTED EFFECTIVE AS OF THE DATE OF LOSS OF COVERAGE IF THE POLICYHOLDER PROVIDES NOTICE OF LOSS OF COVERAGE WITHIN 90 DAYS AFTER THE DATE OF THE LOSS AND PAYS THE PREMIUM ATTRIBUTABLE TO THE PERIOD, EFFECTIVE AS OF THE DATE OF TERMINATION OF ENROLLMENT IN THE GROUP HEALTH PLAN. All of the following apply to the reinstitution of a medicare supplement policy under this subsection:

(A) ~~(*i*)~~ The reinstitution shall not provide for any waiting period with respect to treatment of preexisting conditions.

(B) ~~(*ii*)~~ Reinstituted coverage shall be substantially equivalent to coverage in effect before the date of the suspension.

(C) ~~(*iii*)~~ Classification of premiums for reinstituted coverage shall be on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that

would have applied to the policyholder or certificate holder had the coverage not been suspended.

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

(2) IF AN APPLICANT QUALIFIES UNDER SUBSECTION (1), SUBMITS AN APPLICATION DURING THE TIME PERIOD PROVIDED IN SUBSECTION (1), AND AS OF THE DATE OF APPLICATION HAS HAD A CONTINUOUS PERIOD OF CREDITABLE COVERAGE OF NOT LESS THAN 6 MONTHS, THE INSURER SHALL NOT EXCLUDE BENEFITS BASED ON A PREEXISTING CONDITION. IF THE APPLICANT QUALIFIES UNDER SUBSECTION (1), SUBMITS AN APPLICATION DURING THE TIME PERIOD IN SUBSECTION (1), AND AS OF THE DATE OF APPLICATION HAS HAD A CONTINUOUS PERIOD OF CREDITABLE COVERAGE THAT IS LESS THAN 6 MONTHS, THE INSURER SHALL REDUCE THE PERIOD OF ANY PREEXISTING CONDITION EXCLUSION BY THE AGGREGATE OF THE PERIOD OF CREDITABLE COVERAGE APPLICABLE TO THE APPLICANT AS OF THE ENROLLMENT DATE. THE SECRETARY SHALL SPECIFY THE MANNER OF THE REDUCTION UNDER THIS SUBSECTION.

(3) EXCEPT AS PROVIDED IN SUBSECTION (2) AND SECTION 3833, SUBSECTION (1) DOES NOT PREVENT THE EXCLUSION OF BENEFITS UNDER A POLICY, DURING THE FIRST 6 MONTHS, BASED ON A PREEXISTING CONDITION FOR WHICH THE POLICYHOLDER OR CERTIFICATE HOLDER RECEIVED TREATMENT OR WAS OTHERWISE DIAGNOSED DURING THE 6 MONTHS BEFORE THE COVERAGE BECAME EFFECTIVE.

(4) "CREDITABLE COVERAGE" DOES NOT INCLUDE ANY OF THE FOLLOWING:

(A) ONE OR MORE OF THE FOLLOWING:

(*i*) COVERAGE ONLY FOR ACCIDENT OR DISABILITY INCOME INSURANCE, OR ANY COMBINATION OF ACCIDENT OR DISABILITY INCOME INSURANCE.

(*ii*) COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE.

(*iii*) LIABILITY INSURANCE, INCLUDING GENERAL LIABILITY INSURANCE AND AUTOMOBILE LIABILITY INSURANCE.

(*iv*) WORKERS' COMPENSATION OR SIMILAR INSURANCE.

(*v*) AUTOMOBILE MEDICAL PAYMENT INSURANCE.

(*vi*) CREDIT-ONLY INSURANCE.

(*vii*) COVERAGE FOR ON-SITE MEDICAL CLINICS.

(*viii*) OTHER SIMILAR INSURANCE COVERAGE, SPECIFIED IN FEDERAL REGULATIONS, UNDER WHICH BENEFITS FOR MEDICAL CARE ARE SECONDARY OR INCIDENTAL TO OTHER INSURANCE BENEFITS.

(B) THE FOLLOWING BENEFITS IF THEY ARE PROVIDED UNDER A SEPARATE POLICY, CERTIFICATE, OR CONTRACT OF INSURANCE OR ARE OTHERWISE NOT AN INTEGRAL PART OF THE PLAN:

(*i*) LIMITED SCOPE DENTAL OR VISION BENEFITS.

(*ii*) BENEFITS FOR LONG-TERM CARE, NURSING HOME CARE, HOME HEALTH CARE, COMMUNITY-BASED CARE, OR ANY COMBINATION OF LONG-TERM CARE, NURSING HOME CARE, HOME HEALTH CARE, OR COMMUNITY-BASED CARE.

(*iii*) SUCH OTHER SIMILAR, LIMITED BENEFITS AS ARE SPECIFIED IN FEDERAL REGULATIONS.

(C) THE FOLLOWING BENEFITS IF OFFERED AS INDEPENDENT, NONCO-ORDINATED BENEFITS:

(*i*) COVERAGE ONLY FOR A SPECIFIED DISEASE OR ILLNESS.

(*ii*) HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE.

(D) THE FOLLOWING IF IT IS OFFERED AS A SEPARATE POLICY, CERTIFICATE, OR CONTRACT OF INSURANCE:

(*i*) MEDICARE SUPPLEMENTAL POLICY AS DEFINED UNDER SECTION 1882(G)(1) OF PART D OF MEDICARE, 42 U.S.C. 1395ss.

(*ii*) COVERAGE SUPPLEMENTAL TO THE COVERAGE PROVIDED UNDER CHAPTER 55 OF TITLE 10 OF THE UNITED STATES CODE, 10 U.S.C. 1071 TO 1109.

(*iii*) SIMILAR SUPPLEMENTAL COVERAGE PROVIDED TO COVERAGE UNDER A GROUP HEALTH PLAN.

SEC. 3830. (1) AN ELIGIBLE PERSON IS AN INDIVIDUAL DESCRIBED IN SUBSECTION (2) WHO APPLIES TO ENROLL UNDER A MEDI-CARE SUPPLEMENT POLICY DURING THE PERIOD DESCRIBED IN SUBSECTION (3), AND WHO SUBMITS EVIDENCE OF THE DATE OF TERMINA-TION OR DISENROLLMENT WITH THE APPLICATION FOR A MEDICARE SUPPLE-MENT POLICY. FOR AN ELIGIBLE PERSON, AN INSURER SHALL NOT DENY OR CONDITION THE ISSUANCE OR EFFECTIVENESS OF A MEDICARE

SUPPLEMENT POLICY DESCRIBED IN SUBSECTIONS (5), (6), AND (7) THAT IS OFFERED AND IS AVAILABLE FOR ISSUANCE TO NEW ENROLLEES BY THE INSURER, SHALL NOT DISCRIMINATE IN THE PRICING 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 THAT MEETS ANY OF THE FOLLOWING:

(A) IS ENROLLED UNDER AN EMPLOYEE WELFARE BENEFIT PLAN THAT PROVIDES HEALTH BENEFITS THAT SUPPLEMENT THE BENEFITS UNDER MEDICARE AND THE PLAN TERMINATES OR THE PLAN CEASES TO PROVIDE ALL THOSE SUPPLEMENTAL HEALTH BENEFITS TO THE INDIVIDUAL.

(B) IS ENROLLED WITH A MEDICARE+CHOICE ORGANIZATION UNDER A MEDICARE+CHOICE PLAN UNDER PART C OF MEDICARE, AND ANY OF THE FOLLOWING CIRCUMSTANCES APPLY, OR THE INDIVIDUAL IS 65 YEARS OF AGE OR OLDER AND IS ENROLLED WITH A PACE PROVIDER UNDER SECTION 1894 OF THE SOCIAL SECURITY ACT, AND THERE ARE CIRCUMSTANCES SIMILAR TO THOSE DESCRIBED BELOW THAT WOULD PERMIT DISCONTINUANCE OF THE INDIVIDUAL'S ENROLLMENT WITH THE PROVIDER IF THE INDIVIDUAL WERE ENROLLED IN A MEDICARE+CHOICE PLAN:

(*i*) THE CERTIFICATION OF THE ORGANIZATION OR PLAN HAS BEEN TERMINATED.

(*ii*) THE ORGANIZATION HAS TERMINATED OR OTHERWISE DISCONTINUED PROVIDING THE PLAN IN THE AREA IN WHICH THE INDIVIDUAL RESIDES.

(*iii*) THE INDIVIDUAL IS NO LONGER ELIGIBLE TO ELECT THE PLAN BECAUSE OF A CHANGE IN THE INDIVIDUAL'S PLACE OF RESIDENCE OR OTHER CHANGE IN CIRCUMSTANCES SPECIFIED BY THE SECRETARY, BUT NOT INCLUDING TERMINATION OF THE INDIVIDUAL'S ENROLLMENT ON THE BASIS DESCRIBED IN SECTION 1851(G)(3)(B) OF THE SOCIAL SECURITY ACT, WHERE THE INDIVIDUAL HAS NOT PAID PREMIUMS ON A TIMELY BASIS OR HAS ENGAGED IN DISRUPTIVE BEHAVIOR AS SPECIFIED IN STANDARDS ESTABLISHED UNDER SECTION 1856 OF THE SOCIAL SECURITY ACT, OR THE PLAN IS TERMINATED FOR ALL INDIVIDUALS WITHIN A RESIDENCE AREA.

(*iv*) THE INDIVIDUAL DEMONSTRATES, IN ACCORDANCE WITH GUIDELINES ESTABLISHED BY THE SECRETARY, THAT THE ORGANIZATION OFFERING THE PLAN SUBSTANTIALLY VIOLATED A MATERIAL PROVISION OF THE ORGANIZATION'S CONTRACT IN RELATION TO THE INDIVIDUAL, INCLUDING THE FAILURE TO PROVIDE AN ENROLLEE ON A TIMELY BASIS MEDICALLY NECESSARY CARE FOR WHICH BENEFITS ARE AVAILABLE UNDER THE PLAN OR THE FAILURE TO PROVIDE COVERED CARE IN ACCORDANCE WITH APPLICABLE QUALITY STANDARDS, OR THE ORGANIZATION, OR AGENT OR OTHER ENTITY ACTING ON THE ORGANIZATION'S BEHALF, MATERIALLY MISREPRESENTED THE PLAN'S PROVISIONS IN MARKETING THE PLAN TO THE INDIVIDUAL.

(*v*) THE INDIVIDUAL MEETS OTHER EXCEPTIONAL CONDITIONS AS THE SECRETARY MAY PROVIDE.

(C) IS ENROLLED WITH AN ELIGIBLE ORGANIZATION UNDER A CONTRACT UNDER SECTION 1876 OF THE SOCIAL SECURITY ACT, A SIMILAR ORGANIZATION OPERATING UNDER DEMONSTRATION PROJECT AUTHORITY, EFFECTIVE FOR PERIODS BEFORE APRIL 1, 1999, AN ORGANIZATION UNDER AN AGREEMENT UNDER SECTION 1833(A)(1)(A) OF THE SOCIAL SECURITY ACT, HEALTH CARE PREPAYMENT PLAN, OR AN ORGANIZATION UNDER A

MEDICARE SELECT POLICY, AND THE ENROLLMENT CEASES UNDER THE SAME CIRCUMSTANCES THAT WOULD PERMIT DISCONTINUANCE OF AN INDIVIDUAL'S ELECTION OF COVERAGE UNDER SUBDIVISION (B).

(D) IS ENROLLED UNDER A MEDICARE SUPPLEMENT POLICY AND THE ENROLLMENT CEASES BECAUSE OF ANY OF THE FOLLOWING:

(*i*) THE INSOLVENCY OF THE INSURER OR BANKRUPTCY OF THE NON-INSURER ORGANIZATION OR OF OTHER INVOLUNTARY TERMINATION OF COVERAGE OR ENROLLMENT UNDER THE POLICY.

(*ii*) THE INSURER SUBSTANTIALLY VIOLATED A MATERIAL PROVISION OF THE POLICY.

(*iii*) THE INSURER, OR AN AGENT OR OTHER ENTITY ACTING ON THE INSURER'S BEHALF, MATERIALLY MISREPRESENTED THE POLICY'S PROVISIONS IN MARKETING THE POLICY TO THE INDIVIDUAL.

(E) WAS ENROLLED UNDER A MEDICARE SUPPLEMENT POLICY AND TERMINATES ENROLLMENT AND SUBSEQUENTLY ENROLLS, FOR THE FIRST TIME, WITH ANY MEDICARE+CHOICE ORGANIZATION UNDER A MEDICARE+CHOICE PLAN UNDER PART C OF MEDICARE, ANY ELIGIBLE ORGANIZATION UNDER A CONTRACT UNDER SECTION 1876 OF THE SOCIAL SECURITY ACT, MEDICARE COST, ANY SIMILAR ORGANIZATION OPERATING UNDER DEMONSTRATION PROJECT AUTHORITY, ANY PACE PROVIDER UNDER SECTION 1894 OF THE SOCIAL SECURITY ACT, OR A MEDICARE SELECT POLICY; AND THE SUBSEQUENT ENROLLMENT IS TERMINATED BY THE ENROLLEE DURING ANY PERIOD WITHIN THE FIRST 12 MONTHS OF THE SUBSEQUENT ENROLLMENT DURING WHICH THE ENROLLEE IS PERMITTED TO TERMINATE THE SUBSEQUENT ENROLLMENT UNDER SECTION 1851(E) OF THE SOCIAL SECURITY ACT.

(F) UPON FIRST BECOMING ELIGIBLE FOR BENEFITS UNDER PART A OF MEDICARE AT AGE 65, ENROLLS IN A MEDICARE+CHOICE PLAN UNDER

PART C OF MEDICARE, OR WITH A PACE PROVIDER UNDER SECTION 1894 OF THE SOCIAL SECURITY ACT, AND DISENROLLS FROM THE PLAN OR PROGRAM BY NOT LATER THAN 12 MONTHS AFTER THE EFFECTIVE DATE OF ENROLLMENT.

(3) THE GUARANTEED ISSUE TIME PERIODS UNDER THIS SECTION ARE AS FOLLOWS:

(A) FOR AN INDIVIDUAL DESCRIBED IN SUBSECTION (2)(A), THE GUARANTEED ISSUE TIME PERIOD BEGINS ON THE DATE THE INDIVIDUAL RECEIVES A NOTICE OF TERMINATION OR CESSATION OF ALL SUPPLEMENTAL HEALTH BENEFITS OR, IF A NOTICE IS NOT RECEIVED, NOTICE THAT A CLAIM HAS BEEN DENIED BECAUSE OF A TERMINATION OR CESSATION, AND ENDS 63 DAYS AFTER THE DATE OF THE APPLICABLE NOTICE.

(B) FOR AN INDIVIDUAL DESCRIBED IN SUBSECTION (2)(B), (C), (E), OR (F) WHOSE ENROLLMENT IS TERMINATED INVOLUNTARILY, THE GUARANTEED ISSUE TIME PERIOD BEGINS ON THE DATE THAT THE INDIVIDUAL RECEIVES A NOTICE OF TERMINATION AND ENDS 63 DAYS AFTER THE DATE THE APPLICABLE COVERAGE IS TERMINATED.

(C) FOR AN INDIVIDUAL DESCRIBED IN SUBSECTION (2)(D)(*i*), THE GUARANTEED ISSUE TIME PERIOD BEGINS ON THE EARLIER OF THE DATE THAT THE INDIVIDUAL RECEIVES A NOTICE OF TERMINATION, A NOTICE OF THE ISSUER'S BANKRUPTCY OR INSOLVENCY, OR OTHER SUCH SIMILAR NOTICE, IF ANY, OR THE DATE THAT THE APPLICABLE COVERAGE IS TERMINATED, AND ENDS ON THE DATE THAT IS 63 DAYS AFTER THE DATE 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) 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 INTERVENING ENROLLMENT, ENROLLS IN ANOTHER SUCH PLAN OR PROGRAM, THE SUBSEQUENT ENROLLMENT SHALL BE CONSIDERED AN INITIAL ENROLLMENT DESCRIBED IN SUBSECTION (2)(F). FOR PURPOSES OF SUBSECTIONS (2)(E) AND (F), AN ENROLLMENT OF AN INDIVIDUAL WITH AN ORGANIZATION OR PROVIDER DESCRIBED IN SUBSECTION (2)(E), OR WITH A PLAN OR PROVIDER DESCRIBED IN SUBSECTION (2)(F), SHALL NOT BE CONSIDERED TO BE AN INITIAL ENROLLMENT AFTER THE 2-YEAR PERIOD BEGINNING ON THE DATE ON WHICH THE INDIVIDUAL FIRST ENROLLED WITH SUCH AN ORGANIZATION, PROVIDER, OR PLAN.

(5) THE MEDICARE SUPPLEMENT POLICY TO WHICH AN ELIGIBLE PERSON IS ENTITLED UNDER SUBSECTION (2)(A), (B), (C), AND (D) IS

A MEDICARE SUPPLEMENT POLICY THAT HAS A BENEFIT PACKAGE CLASSIFIED AS PLAN A, B, C, OR F OFFERED BY ANY INSURER.

(6) THE MEDICARE SUPPLEMENT POLICY TO WHICH AN ELIGIBLE PERSON IS ENTITLED UNDER SUBSECTION (2)(E) IS THE SAME MEDICARE SUPPLEMENT POLICY IN WHICH THE INDIVIDUAL WAS MOST RECENTLY PREVIOUSLY ENROLLED, IF AVAILABLE FROM THE SAME INSURER, OR, IF NOT SO AVAILABLE, A POLICY DESCRIBED IN SUBSECTION (5).

(7) THE MEDICARE SUPPLEMENT POLICY TO WHICH AN ELIGIBLE PERSON IS ENTITLED UNDER SUBSECTION (2)(F) SHALL INCLUDE ANY MEDICARE SUPPLEMENT POLICY OFFERED BY ANY INSURER.

SEC. 3830A. (1) AT THE TIME OF AN EVENT DESCRIBED IN SECTION 3830(2) BECAUSE OF WHICH AN INDIVIDUAL LOSES COVERAGE OR BENEFITS DUE TO THE TERMINATION OF A CONTRACT OR AGREEMENT, POLICY, OR PLAN, THE ORGANIZATION THAT TERMINATES THE CONTRACT OR AGREEMENT, THE INSURER TERMINATING THE POLICY, OR THE ADMINISTRATOR OF THE PLAN BEING TERMINATED, RESPECTIVELY, SHALL NOTIFY THE INDIVIDUAL OF HIS OR HER RIGHTS UNDER SECTION 3830 AND OF THE OBLIGATIONS OF INSURERS OF MEDICARE SUPPLEMENT POLICIES UNDER SECTION 3830(1). THE NOTICE SHALL BE COMMUNICATED CONTEMPORANEOUSLY WITH THE NOTIFICATION OF TERMINATION.

(2) AT THE TIME OF AN EVENT DESCRIBED IN SECTION 3830(2) BECAUSE OF WHICH AN INDIVIDUAL CEASES ENROLLMENT UNDER A CONTRACT OR AGREEMENT, POLICY, OR PLAN, THE ORGANIZATION THAT OFFERS THE CONTRACT OR AGREEMENT, REGARDLESS OF THE BASIS FOR THE CESSATION OF ENROLLMENT, THE INSURER OFFERING THE POLICY, OR THE ADMINISTRATOR OF THE PLAN, RESPECTIVELY, SHALL NOTIFY THE INDIVIDUAL OF HIS OR HER RIGHTS UNDER SECTION 3830 AND OF THE OBLIGATIONS OF

INSURERS OF MEDICARE SUPPLEMENT POLICIES UNDER SECTION 3830(1). THE NOTICE SHALL BE COMMUNICATED WITHIN 10 WORKING DAYS OF THE INSURER RECEIVING NOTIFICATION OF DISENROLLMENT.

Enacting section 1. Section 3837 of the insurance code of 1956, 1956 PA 218, MCL 500.3837, is repealed.