

SENATE BILL No. 748

October 18, 2001, Introduced by Senator HAMMERSTROM and referred to the
Committee on Financial Services.

A bill to amend 1956 PA 218, entitled
"The insurance code of 1956,"
by amending sections 3801, 3807, 3809, 3811, 3815, 3819, and 3829
(MCL 500.3801, 500.3807, 500.3809, 500.3811, 500.3815, 500.3819,
and 500.3829), as added by 1992 PA 84, and by adding sections
3830 and 3830a.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

- 1 Sec. 3801. As used in this chapter:
- 2 (a) "Applicant" means:
- 3 (i) For an individual medicare supplement policy, the person
- 4 who seeks to contract for insurance benefits.
- 5 (ii) For a group medicare supplement policy, the proposed
- 6 certificate holder.
- 7 (B) "BANKRUPTCY" MEANS WHEN A MEDICARE+CHOICE ORGANIZATION
- 8 THAT IS NOT AN INSURER HAS FILED, OR HAS HAD FILED AGAINST IT, A

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

3 (C) ~~-(b)-~~ "Certificate" means any certificate delivered or
4 issued for delivery in this state under a group medicare supple-
5 ment policy.

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

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

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

14 (i) A GROUP HEALTH PLAN.

15 (ii) HEALTH INSURANCE COVERAGE.

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

17 (iv) MEDICAID OTHER THAN COVERAGE CONSISTING SOLELY OF BENE-
18 FITS UNDER SECTION 1928 OF MEDICAID, 42 U.S.C. 1396s.

19 (v) CHAPTER 55 OF TITLE 10 OF THE UNITED STATES CODE, 10
20 U.S.C. 1071 TO 1109.

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

23 (vii) A STATE HEALTH BENEFITS RISK POOL.

24 (viii) A HEALTH PLAN OFFERED UNDER CHAPTER 89 OF TITLE 5 OF
25 THE UNITED STATES CODE, 5 U.S.C. 8901 TO 8914.

26 (ix) A PUBLIC HEALTH PLAN AS DEFINED IN FEDERAL REGULATION.

1 (x) HEALTH CARE UNDER SECTION 5(e) OF TITLE I OF THE PEACE
2 CORPS ACT, PUBLIC LAW 87-293, 22 U.S.C. 2504.

3 (G) ~~-(d)-~~ "Direct response solicitation" means solicitation
4 in which an insurer representative does not contact the applicant
5 in person and explain the coverage available, such as, but not
6 limited to, solicitation through direct mail or through adver-
7 tisements in periodicals and other media.

8 (H) "EMPLOYEE WELFARE BENEFIT PLAN" MEANS A PLAN, FUND, OR
9 PROGRAM OF EMPLOYEE BENEFITS AS DEFINED IN SECTION 3 OF SUBTITLE
10 A OF TITLE I OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF
11 1974, PUBLIC LAW 93-406, 29 U.S.C. 1002.

12 (I) "INSOLVENCY" MEANS WHEN AN INSURER LICENSED TO TRANSACT
13 THE BUSINESS OF INSURANCE IN THIS STATE HAS HAD A FINAL ORDER OF
14 LIQUIDATION ENTERED AGAINST IT WITH A FINDING OF INSOLVENCY BY A
15 COURT OF COMPETENT JURISDICTION IN THE INSURER'S STATE OF
16 DOMICILE.

17 (J) "INSURER" INCLUDES ANY ENTITY, INCLUDING A HEALTH CARE
18 CORPORATION, DELIVERING OR ISSUING FOR DELIVERY IN THIS STATE
19 MEDICARE SUPPLEMENT POLICIES.

20 (K) ~~-(e)-~~ "Medicaid" means ~~title XIX of the social security~~
21 ~~act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396f, and~~
22 ~~1396i to 1396u~~ TITLE XIX OF THE SOCIAL SECURITY ACT, CHAPTER
23 531, 49 STAT. 620, 42 U.S.C. 1396 TO 1396r-6 AND 1396r-8 TO
24 1396v.

25 (l) ~~-(f)-~~ "Medicare" means title XVIII of the social secur-
26 ity act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b,
27 1395b-2, ~~1395c to 1395i, 1395i-2 to 1395i-4, 1395j to 1395t,~~

1 ~~1395u to 1395w-2, 1395w-4 to 1395zz, and 1395bbb to 1395ccc~~
 2 1395b-6 TO 1395b-7, 1395c TO 1395i, 1395i-2 TO 1395i-5, 1395j TO
 3 1395t, 1395u TO 1395w, 1395w-2 TO 1395w-4, 1395w-21 TO 1395w-28,
 4 1395x TO 1395yy, AND 1395bbb TO 1395ggg.

5 (M) "MEDICARE+CHOICE PLAN" MEANS A PLAN OF COVERAGE FOR
 6 HEALTH BENEFITS UNDER MEDICARE PART C AS DEFINED IN SECTION
 7 12-2859 OF PART C OF MEDICARE, 42 U.S.C. 1395w-28, AND INCLUDES
 8 ANY OF THE FOLLOWING:

9 (i) COORDINATED CARE PLANS THAT PROVIDE HEALTH CARE SERV-
 10 ICES, INCLUDING, BUT NOT LIMITED TO, HEALTH MAINTENANCE ORGANIZA-
 11 TION PLANS WITH OR WITHOUT A POINT-OF-SERVICE OPTION, PLANS
 12 OFFERED BY PROVIDER-SPONSORED ORGANIZATIONS, AND PREFERRED PRO-
 13 VIDER ORGANIZATION PLANS.

14 (ii) MEDICAL SAVINGS ACCOUNT PLANS COUPLED WITH A CONTRIBU-
 15 TION INTO A MEDICARE+CHOICE MEDICAL SAVINGS ACCOUNT.

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

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

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

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

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

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

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

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

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

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

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

4 (c) Upon exhaustion of the medicare hospital inpatient cov-
5 erage including the lifetime reserve days, coverage of the medi-
6 care part A eligible expenses for hospitalization paid at the
7 diagnostic related group day outlier per diem or other appropri-
8 ate standard of payment, subject to a lifetime maximum benefit of
9 an additional 365 days.

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

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

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

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

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

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

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

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

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

17 (f) Basic outpatient prescription drug benefit: coverage
18 for 50% of outpatient prescription drug charges, after a \$250.00
19 calendar year deductible, to a maximum of \$1,250.00 in benefits
20 received by the insured per calendar year, to the extent not cov-
21 ered by medicare.

22 (g) Extended outpatient prescription drug benefit: coverage
23 for 50% of outpatient prescription drug charges, after a \$250.00
24 calendar year deductible, to a maximum of \$3,000.00 in benefits
25 received by the insured per calendar year, to the extent not cov-
26 ered by medicare.

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

13 (i) Preventive medical care benefit: Coverage for the fol-
 14 lowing preventive health services:

15 (i) An annual clinical preventive medical history and physi-
 16 cal examination that may include tests and services from
 17 subparagraph (ii) and patient education to address preventive
 18 health care measures.

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

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

24 ~~(B) Mammogram.~~

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

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

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

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

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

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

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

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

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

- 1 (ii) The actual charges for each visit up to a maximum
2 reimbursement of \$40.00 per visit.
- 3 (iii) One thousand six hundred dollars per calendar year.
- 4 (iv) Seven visits in any 1 week.
- 5 (v) Care furnished on a visiting basis in the insured's
6 home.
- 7 (vi) Services provided by a care provider as defined in this
8 section.
- 9 (vii) At-home recovery visits while the insured is covered
10 under the insurance policy and not otherwise excluded.
- 11 (viii) At-home recovery visits received during the period
12 the insured is receiving medicare approved home care services or
13 no more than 8 weeks after the service date of the last medicare
14 approved home health care visit.
- 15 (k) New or innovative benefits: an insurer may, with the
16 prior approval of the commissioner, offer new or innovative bene-
17 fits in addition to the benefits provided in a policy or certifi-
18 cate that otherwise complies with the applicable standards.
19 These benefits may include benefits that are appropriate to medi-
20 care supplement insurance, new or innovative, not otherwise
21 available, cost-effective, and offered in a manner that is con-
22 sistent with the goal of simplification of medicare supplement
23 policies.
- 24 (2) Reimbursement for the preventive screening tests and
25 services under subsection (1)(i)(ii) shall be for the actual
26 charges up to 100% of the medicare-approved amount for each test
27 or service, as if medicare were to cover the test or service as

1 identified in the American medical association current procedural
2 terminology codes, to a maximum of \$120.00 annually under this
3 benefit. This benefit shall not include payment for any proce-
4 dure covered by medicare.

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

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

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

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

18 (d) "At-home recovery visit" means the period of a visit
19 required to provide at home recovery care, without limit on the
20 duration of the visit, except each consecutive 4 hours in a
21 24-hour period of services provided by a care provider is 1
22 visit.

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

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

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

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

16 (5) A medicare supplement insurance benefit plan shall con-
17 form to 1 of the following:

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

21 (b) A standardized medicare supplement benefit plan B shall
22 include only the following: the core benefits as defined in sec-
23 tion 3807 and the medicare part A deductible as defined in sec-
24 tion 3809(1)(a).

25 (c) A standardized medicare supplement benefit plan C shall
26 include only the following: the core benefits as defined in
27 section 3807, the medicare part A deductible, skilled nursing

1 facility care, medicare part B deductible, and medically
2 necessary emergency care in a foreign country as defined in sec-
3 tion 3809(1)(a), (b), (c), and (h).

4 (d) A standardized medicare supplement benefit plan D shall
5 include only the following: the core benefits as defined in sec-
6 tion 3807, the medicare part A deductible, skilled nursing facil-
7 ity care, medically necessary emergency care in a foreign coun-
8 try, and the at-home recovery benefit as defined in section
9 3809(1)(a), (b), (h), and (j).

10 (e) A standardized medicare supplement benefit plan E shall
11 include only the following: the core benefits as defined in sec-
12 tion 3807, the medicare part A deductible, skilled nursing facil-
13 ity care, medically necessary emergency care in a foreign coun-
14 try, and preventive medical care as defined in section
15 3809(1)(a), (b), (h), and (i).

16 (f) A standardized medicare supplement benefit plan F shall
17 include only the following: the core benefits as defined in sec-
18 tion 3807, the medicare part A deductible, skilled nursing facil-
19 ity care, medicare part B deductible, 100% of the medicare part B
20 excess charges, and medically necessary emergency care in a for-
21 eign country as defined in section 3809(1)(a), (b), (c), (e), and
22 (h). A STANDARDIZED MEDICARE SUPPLEMENT PLAN F HIGH DEDUCTIBLE
23 SHALL INCLUDE ONLY THE FOLLOWING: 100% OF COVERED EXPENSES FOL-
24 LOWING THE PAYMENT OF THE ANNUAL HIGH DEDUCTIBLE PLAN F
25 DEDUCTIBLE. THE COVERED EXPENSES INCLUDE THE CORE BENEFITS AS
26 DEFINED IN SECTION 3807, PLUS THE MEDICARE PART A DEDUCTIBLE,
27 SKILLED NURSING FACILITY CARE, THE MEDICARE PART B DEDUCTIBLE,

1 100% OF THE MEDICARE PART B EXCESS CHARGES, AND MEDICALLY
2 NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY AS DEFINED IN SEC-
3 TION 3809(1)(A), (B), (C), (E), AND (H). THE ANNUAL HIGH DEDUCT-
4 IBLE PLAN F DEDUCTIBLE SHALL CONSIST OF OUT-OF-POCKET EXPENSES,
5 OTHER THAN PREMIUMS, FOR SERVICES COVERED BY THE MEDICARE SUPPLE-
6 MENT PLAN F POLICY, AND SHALL BE IN ADDITION TO ANY OTHER SPE-
7 CIFIC BENEFIT DEDUCTIBLES. THE ANNUAL HIGH DEDUCTIBLE PLAN F
8 DEDUCTIBLE IS \$1,580.00 FOR CALENDAR YEAR 2001, AND THE SECRETARY
9 SHALL ADJUST IT ANNUALLY THEREAFTER TO REFLECT THE CHANGE IN THE
10 CONSUMER PRICE INDEX FOR ALL URBAN CONSUMERS FOR THE 12-MONTH
11 PERIOD ENDING WITH AUGUST OF THE PRECEDING YEAR, ROUNDED TO THE
12 NEAREST MULTIPLE OF \$10.00.

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

20 (h) A standardized medicare supplement benefit plan H shall
21 include only the following: the core benefits as defined in sec-
22 tion 3807, the medicare part A deductible, skilled nursing facil-
23 ity care, basic outpatient prescription drug benefit, and medi-
24 cally necessary emergency care in a foreign country as defined in
25 section 3809(1)(a), (b), (f), and (h).

26 (i) A standardized medicare supplement benefit plan I shall
27 include only the following: the core benefits as defined in

1 section 3807, the medicare part A deductible, skilled nursing
2 facility care, 100% of the medicare part B excess charges, basic
3 outpatient prescription drug benefit, medically necessary emer-
4 gency care in a foreign country, and at-home recovery benefit as
5 defined in section 3809(1)(a), (b), (e), (f), (h), and (j).

6 (j) A standardized medicare supplement benefit plan J shall
7 include only the following: the core benefits as defined in sec-
8 tion 3807, the medicare part A deductible, skilled nursing facil-
9 ity care, medicare part B deductible, 100% of the medicare part B
10 excess charges, extended outpatient prescription drug benefit,
11 medically necessary emergency care in a foreign country, preven-
12 tive medical care, and at-home recovery benefit as defined in
13 section 3809(1)(a), (b), (c), (e), (g), (h), (i), and (j). A
14 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN J HIGH DEDUCTIBLE
15 PLAN SHALL CONSIST OF ONLY THE FOLLOWING: 100% OF COVERED
16 EXPENSES FOLLOWING THE PAYMENT OF THE ANNUAL HIGH DEDUCTIBLE PLAN
17 J DEDUCTIBLE. THE COVERED EXPENSES INCLUDE THE CORE BENEFITS AS
18 DEFINED IN SECTION 3807, PLUS THE MEDICARE PART A DEDUCTIBLE,
19 SKILLED NURSING FACILITY CARE, MEDICARE PART B DEDUCTIBLE, 100%
20 OF THE MEDICARE PART B EXCESS CHARGES, EXTENDED OUTPATIENT PRE-
21 SCRIPTON DRUG BENEFIT, MEDICALLY NECESSARY EMERGENCY CARE IN A
22 FOREIGN COUNTRY, PREVENTIVE MEDICAL CARE BENEFIT AND AT-HOME
23 RECOVERY BENEFIT AS DEFINED IN SECTION 3809(1)(A), (B), (C), (E),
24 (G), (H), (I), AND (J). THE ANNUAL HIGH DEDUCTIBLE PLAN J
25 DEDUCTIBLE SHALL CONSIST OF OUT-OF-POCKET EXPENSES, OTHER THAN
26 PREMIUMS, FOR SERVICES COVERED BY THE MEDICARE SUPPLEMENT PLAN J
27 POLICY, AND SHALL BE IN ADDITION TO ANY OTHER SPECIFIC BENEFIT

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

6 Sec. 3815. (1) An insurer that offers a medicare supplement
7 policy shall provide to the applicant at the time of application
8 an outline of coverage and, except for direct response sollicita-
9 tion policies, shall obtain an acknowledgment of receipt of the
10 outline of coverage from the applicant. The outline of coverage
11 provided to applicants pursuant to this section shall consist of
12 the following 4 parts:

13 (a) A cover page.

14 (b) Premium information.

15 (c) Disclosure pages.

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

18 (2) IF AN OUTLINE OF COVERAGE IS PROVIDED AT THE TIME OF
19 APPLICATION AND THE MEDICARE SUPPLEMENT POLICY OR CERTIFICATE IS
20 ISSUED ON A BASIS THAT WOULD REQUIRE REVISION OF THE OUTLINE, A
21 SUBSTITUTE OUTLINE OF COVERAGE PROPERLY DESCRIBING THE POLICY OR
22 CERTIFICATE SHALL ACCOMPANY THE POLICY OR CERTIFICATE WHEN IT IS
23 DELIVERED AND SHALL CONTAIN THE FOLLOWING STATEMENT, IN NO LESS
24 THAN 12-POINT TYPE, IMMEDIATELY ABOVE THE COMPANY NAME:

25 NOTICE: READ THIS OUTLINE OF COVERAGE
26 CAREFULLY. IT IS NOT IDENTICAL TO THE
27 OUTLINE OF COVERAGE PROVIDED UPON

1 APPLICATION AND THE COVERAGE ORIGINALLY

2 APPLIED FOR HAS NOT BEEN ISSUED.

3 (3) ~~-(2)-~~ An outline of coverage under subsection (1) shall
4 be in the language and format prescribed in this section and in
5 not less than 12-point type. The A through J letter designation
6 of the plan shall be shown on the cover page and the plans
7 offered by the insurer shall be prominently identified. Premium
8 information shall be shown on the cover page or immediately fol-
9 lowing the cover page and shall be prominently displayed. The
10 premium and method of payment mode shall be stated for all plans
11 that are offered to the applicant. All possible premiums for the
12 applicant shall be illustrated. The following items shall be
13 included in the outline of coverage in the order prescribed below
14 and in substantially the following form, as approved by the
15 commissioner:

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

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

8 **BASIC BENEFITS:** Included in All Plans.

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

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

13 Blood: First three pints of blood each year.

	A	B	C	D	E	F	G	H	I	J
15 Basic Benefits	x	x	x	x	x	x	x	x	x	x
19 Skilled Nursing 20 Co-Insurance			x	x	x	x	x	x	x	x
22 Part A Deductible		x	x	x	x	x	x	x	x	x
24 Part B Deductible			x			x				x
26 Part B Excess						x 100%	x 80%		x 100%	x 100%
29 Foreign Travel 30 Emergency			x	x	x	x	x	x	x	x
32 At-Home Recovery				x			x		x	x
34 Drugs								x \$1,250 Limit	x \$1,250 Limit	x \$3,000 Limit
38 Preventive Care					X					x

1 PREMIUM INFORMATION

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

6 DISCLOSURES

7 Use this outline to compare benefits and premiums among pol-
8 icies, certificates, and contracts.

9 READ YOUR POLICY VERY CAREFULLY

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

14 RIGHT TO RETURN POLICY

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

20 POLICY REPLACEMENT

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

24 NOTICE

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

26 [For agent issued policies]

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

3 [For direct response issued policies]

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

5 This outline of coverage does not give all the details of medi-
6 care coverage. Contact your local social security office or con-
7 sult "the medicare handbook" for more details.

8 COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

1 PLAN A
 2 MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD
 3 *A benefit period begins on the first day you receive service as an
 4 inpa-
 5 tient in a hospital and ends after you have been out of the hospital and
 6 have not received skilled care in any other facility for 60 days in a
 7 row.

8	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
11	HOSPITALIZATION*			
12	Semiprivate room and board,			
13	general nursing and mis-			
14	cellaneous services and			
15	supplies			
16	First 60 days	All but -\$628- \$792	\$0	-\$628- \$792
17				(Part A
18				Deductible)
19	61st thru 90th day	All but -\$157- \$198	-\$157- \$198	\$0
20		a day	a day	
21	91st day and after:			
22	--While using 60 lifetime			
23	reserve days	All but -\$314- \$396	-\$314- \$396	\$0
24		a day	a day	
25	--Once lifetime reserve			
26	days are used:			
27	--Additional 365 days	\$0	100% of	\$0
28			Medicare	
29			Eligible	
30			Expenses	
31	--Beyond the			
32	Additional 365 days	\$0	\$0	All Costs
35	SKILLED NURSING FACILITY			
36	CARE*			
37	You must meet Medicare's			
38	requirements, including			
39	having been in a hospital			
40	for at least 3 days and			
41	entered a Medicare-approved			
42	facility within 30 days			
43	after leaving the hospital			
44	First 20 days	All approved		
45		amounts	\$0	\$0
46	21st thru 100th day	All but -\$78.50-	\$0	Up to
47		\$99 a day		-\$78.50- \$99
48				a day
49	101st day and after	\$0	\$0	All costs

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

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

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

PLAN B

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

*A benefit period begins on the first day you receive service as an inpa-

tient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

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

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

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

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

PLAN C

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

*A benefit period begins on the first day you receive service as an inpa-

tient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

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

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2	—			
3	BLOOD			
4	First 3 pints	\$0	3 pints	\$0
5	Additional amounts	100%	\$0	\$0
6	<hr/>			
7	—			
8	HOSPICE CARE			
9	Available as long as your	All but very	\$0	Balance
10	doctor certifies you are	limited coinsurance		
11	terminally ill and you	for outpatient		
12	elect to receive these	drugs and inpatient		
13	services	respite care		
14	<hr/>			
	—			

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

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

OTHER BENEFITS--NOT COVERED BY MEDICARE

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

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

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

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3	—			
4	HOME HEALTH CARE			
5	Medicare Approved			
6	Services			
7	--Medically necessary			
8	skilled care services			
9	and medical supplies	100%	\$0	\$0
10	--Durable medical equip-			
11	ment			
12	First \$100 of Medicare			
13	Approved Amounts*	\$0	\$0	\$100 (Part B
14				Deductible)
15	Remainder of Medicare			
16	Approved Amounts	80%	20%	\$0
17	AT-HOME RECOVERY SERV-			
18	VICES--			
19	Not covered by Medicare			
20	Home care certi-			
21	fied by your doctor, for			
22	personal care during			
23	recovery from an injury			
24	or sickness for which			
25	Medicare approved a Home			
26	Care Treatment Plan			
27	--Benefit for each visit	\$0	Actual Charges	
28			to \$40 a visit	Balance
29	--Number of visits			
30	covered (must be			
31	received within 8			
32	weeks of last Medi-			
33	care Approved visit)	\$0	Up to the num-	
34			ber of Medicare	
35			Approved	
36			visits, not to	
37			exceed 7 each	
38			week	
39	--Calendar year maximum	\$0	\$1,600	
40				

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(continued)

OTHER BENEFITS--NOT COVERED BY MEDICARE

1				
2				
3	—			
4	FOREIGN TRAVEL--			
5	Not covered by Medicare			
6	Medically necessary emer-			
7	gency care services			
8	beginning during the			
9	first 60 days of each			
10	trip outside the USA			
11	First \$250 each			
12	calendar year	\$0	\$0	\$250
13	Remainder of charges	\$0	80% to a life-	20% and
14			time maximum	amounts over
15			benefit of	the \$50,000
16			\$50,000	lifetime
17				maximum
18				

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

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

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 Part B Excess Charges (Above Medicare Approved Amounts)	80%	20%	\$0
	\$0	\$0	All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts*	\$0	All Costs	\$0
Remainder of Medicare Approved Amounts	\$0	\$0	\$100 (Part B Deductible)
	80%	20%	\$0
CLINICAL LABORATORY SERVICES-- Blood tests for diagnostic services	100%	\$0	\$0

(continued)

PARTS A & B

1				
2				
3				
4	HOME HEALTH CARE			
5	Medicare Approved			
6	Services			
7	--Medically necessary			
8	skilled care services			
9	and medical supplies	100%	\$0	\$0
10	--Durable medical equip-			
11	ment			
12	First \$100 of Medicare			
13	Approved Amounts*	\$0	\$0	\$100 (Part B
14				Deductible)
15	Remainder of Medicare			
16	Approved Amounts	80%	20%	\$0
17				
18				
19				
20	OTHER BENEFITS--NOT COVERED BY MEDICARE			
21				
22				
23	FOREIGN TRAVEL--			
24	Not covered by Medicare			
25	Medically necessary emer-			
26	gency care services			
27	beginning during the first			
28	60 days of each trip			
29	outside the USA			
30	First \$250 each			
31	calendar year	\$0	\$0	\$250
32	Remainder of Charges	\$0	80% to a life-	20% and
33			time maximum	amounts over
34			benefit of	the \$50,000
35			\$50,000	lifetime
36				maximum
37				
38				
39	PREVENTIVE MEDICAL CARE			
40	BENEFIT--			
41	Not covered by Medicare			
42	Annual physical and preven-			
43	tive tests and services			
44	such as: fecal occult			
45	blood test, digital			
46	rectal exam, mammogram,			
47	hearing screening, dipstick			
48	urinalysis, diabetes			
49	screening, thyroid func-			
50	tion test, influenza shot,			
51	tetanus and diphtheria			
52	booster and education,			

1	administered or ordered			
2	by your doctor when not			
3	covered by Medicare			
4	First \$120 each			
5	calendar year	\$0	\$120	\$0
6	Additional charges	\$0	\$0	All Costs
7				

1 PLAN F OR HIGH DEDUCTIBLE PLAN F
 2 MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD
 3 *A benefit period begins on the first day you receive service as an
 4 inpa-
 5 tient in a hospital and ends after you have been out of the hospital and
 6 have not received skilled care in any other facility for 60 days in a
 7 row.
 8 **THIS HIGH DEDUCTIBLE PLAN PAYS THE SAME OR OFFERS THE SAME BENEFITS AS
 9 PLAN F AFTER YOU HAVE PAID A CALENDAR YEAR (\$1,580) DEDUCTIBLE.
 10 BENEFITS
 11 FROM THE HIGH DEDUCTIBLE PLAN F WILL NOT BEGIN UNTIL OUT-OF-POCKET
 12 EXPENSES ARE \$1,580. OUT-OF-POCKET EXPENSES FOR THIS DEDUCTIBLE ARE
 13 EXPENSES THAT WOULD ORDINARILY BE PAID BY THE POLICY. THIS INCLUDES
 14 MEDICARE DEDUCTIBLES FOR PART A AND PART B, BUT DOES NOT INCLUDE THE
 15 PLAN'S SEPARATE FOREIGN TRAVEL EMERGENCY DEDUCTIBLE.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$1,580 DEDUCTIBLE**,	IN ADDITION TO \$1,580
DEDUCTIBLE**,		PLAN PAYS	YOU PAY

21 HOSPITALIZATION* 22 Semiprivate room and board, 23 general nursing and mis- 24 cellaneous services and 25 supplies	27 All but -\$628- 28 \$792	27 -\$628- \$792 28 29 (Part A 30 Deductible)	\$0
31 61st thru 90th day	31 All but -\$157- 32 \$198 a day	31 -\$157- 32 \$198 a day	\$0
33 91st day and after 34 --While using 60 lifetime 35 reserve days	35 All but -\$314- 36 \$396 a day	35 -\$314- 36 \$396 a day	\$0
37 --Once lifetime reserve 38 days are used: 39 --Additional 365 days	\$0	39 100% of 40 Medicare 41 Eligible 42 Expenses	\$0
43 --Beyond the 44 Additional 365 days	\$0	\$0	All Costs

46 SKILLED NURSING FACILITY
 47 CARE*
 48 You must meet Medicare's
 49 requirements, including
 50 having been in a hospital
 51 for at least 3 days and

1	entered a Medicare-approved			
2	facility within 30 days			
3	after leaving the hospital			
4	First 20 days	All approved		
5		amounts	\$0	\$0
6	21st thru 100th day	All but	Up to	\$0
7		-\$78.50 \$99	-\$78.50 \$99	
8		a day	a day	
9	101st day and after	\$0	\$0	All costs
10				
11	—			
12	BLOOD			
13	First 3 pints	\$0	3 pints	\$0
14	Additional amounts	100%	\$0	\$0
15				
16	—			
17	HOSPICE CARE			
18	Available as long as your	All but very	\$0	Balance
19	doctor certifies you are	limited coinsurance		
20	terminally ill and you	for outpatient		
21	elect to receive these	drugs and inpatient		
22	services	respite care		
23				
	—			

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

1

2

—

3

CLINICAL LABORATORY

4

SERVICES--

5

Blood tests for diagnostic

6

services

100%

\$0

\$0

7

—

8

(continued)

PARTS A & B

1
2

3

4 HOME HEALTH CARE
5 Medicare Approved
6 Services7 --Medically necessary
8 skilled care services
9 and medical supplies

100%

\$0

\$0

11 --Durable medical equip-
12 ment13 First \$100 of Medicare
14 Approved Amounts*

\$0

\$100 (Part B
Deductible)

\$0

15 Remainder of Medicare
16 Approved Amounts

80%

20%

\$0

17

18

19

20

OTHER BENEFITS--NOT COVERED BY MEDICARE

21

22 FOREIGN TRAVEL--

23 Not covered by Medicare

24 Medically necessary emer-
25 gency care services begin-
26 ning during the first 60
27 days of each trip
28 outside the USA29 First \$250 each
30 calendar year

\$0

\$0

\$250

31 Remainder of charges

\$0

80% to a life-
time maximum
benefit of
\$50,00020% and
amounts over
the \$50,000
lifetime
maximum

32

33

34

35

36

PLAN G

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

*A benefit period begins on the first day you receive service as an inpa-

tient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies	All but -\$628- \$792	-\$628- \$792 (Part A Deductible)	\$0
First 60 days	All but -\$157- \$198 a day	-\$157- \$198 a day	\$0
61st thru 90th day 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	All approved amounts	\$0	\$0
First 20 days	All but -\$78.50- \$99 a day	Up to -\$78.50- \$99 a day	\$0
21st thru 100th day	\$0	\$0	All costs
101st day and after	\$0	\$0	All costs

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

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

1
2

3	—			
4	HOME HEALTH CARE			
5	Medicare Approved			
6	Services			
7	--Medically necessary			
8	skilled care services			
9	and medical supplies	100%	\$0	\$0
10	--Durable medical equip-			
11	ment			
12	First \$100 of Medicare			
13	Approved Amounts*	\$0	\$0	\$100 (Part B
14				Deductible)
15	Remainder of Medicare			
16	Approved Amounts	80%	20%	\$0
17	AT-HOME RECOVERY SERV-			
18	VICES--			
19	Not covered by Medicare			
20	Home care certi-			
21	fied by your doctor, for			
22	personal care during			
23	recovery from an injury			
24	or sickness for which			
25	Medicare approved a Home			
26	Care Treatment Plan			
27	--Benefit for each visit	\$0	Actual Charges	
28			to \$40 a visit	Balance
29	--Number of visits			
30	covered (must be			
31	received within 8			
32	weeks of last Medi-			
33	care Approved visit)	\$0	Up to the num-	
34			ber of Medicare	
35			Approved	
36			visits, not to	
37			exceed 7 each	
38			week	
39	--Calendar year maximum	\$0	\$1,600	
40				

41

(continued)

OTHER BENEFITS--NOT COVERED BY MEDICARE

1				
2				
3	—			
4	FOREIGN TRAVEL--			
5	Not covered by Medicare			
6	Medically necessary emer-			
7	gency care services			
8	beginning during the			
9	first 60 days of each			
10	trip outside the USA			
11	First \$250 each			
12	calendar year	\$0	\$0	\$250
13	Remainder of charges	\$0	80% to a life-	20% and
14			time maximum	amounts over
15			benefit of	the \$50,000
16			\$50,000	lifetime
17				maximum
18				

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

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

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

1				
2				
3				
4	HOME HEALTH CARE			
5	Medicare Approved			
6	Services			
7	--Medically necessary			
8	skilled care services			
9	and medical supplies	100%	\$0	\$0
10	--Durable medical equip-			
11	ment			
12	First \$100 of Medicare			
13	Approved Amounts*	\$0	\$0	\$100 (Part B
14				Deductible)
15	Remainder of Medicare			
16	Approved Amounts	80%	20%	\$0
17				
18				
19				
20	OTHER BENEFITS--NOT COVERED BY MEDICARE			
21				
22				
23	FOREIGN TRAVEL--			
24	Not covered by Medicare			
25	Medically necessary emer-			
26	gency care services			
27	beginning during the first			
28	60 days of each trip			
29	outside the USA			
30	First \$250 each	\$0	\$0	\$250
31	calendar year	\$0	80% to a life-	20% and
32	Remainder of Charges		time maximum	amounts over
33			benefit of	the \$50,000
34			\$50,000	lifetime
35				maximum
36				
37				
38				
39	BASIC OUTPATIENT PRE-			
40	SCRIPTION DRUGS--			
41	Not covered by Medicare			
42	First \$250 each			
43	calendar year	\$0	\$0	\$250
44	Next \$2,500 each	\$0	50%--\$1,250	50%
45	calendar year		calendar year	
46			maximum benefit	
47				
48	Over \$2,500 each			
49	calendar year	\$0	\$0	All Costs
50				

PLAN I

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

*A benefit period begins on the first day you receive service as an inpa-

tient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

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

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

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

1				
2				
3	—			
4	HOME HEALTH CARE			
5	Medicare Approved			
6	Services			
7	--Medically necessary			
8	skilled care services			
9	and medical supplies	100%	\$0	\$0
10	--Durable medical equip-			
11	ment			
12	First \$100 of Medicare			
13	Approved Amounts*	\$0	\$0	\$100 (Part B
14				Deductible)
15	Remainder of Medicare			
16	Approved Amounts	80%	20%	\$0
17	AT-HOME RECOVERY			
18	SERVICES--			
19	Not covered by Medicare			
20	Home care certified by			
21	your doctor, for personal			
22	care during recovery from			
23	an injury or sickness			
24	for which Medicare approved			
25	a Home Care Treatment Plan			Balance
26	--Benefit for each visit	\$0	Actual Charges	
27			to \$40 a visit	
28	--Number of visits cov-	\$0	Up to the num-	
29	ered (must be received		ber of Medicare	
30	within 8 weeks of last		Approved	
31	Medicare Approved		visits, not to	
32	visit)		exceed 7 each	
33			week	
34	--Calendar year maximum	\$0	\$1,600	
35				

36 (continued)

OTHER BENEFITS--NOT COVERED BY MEDICARE

1				
2				
3	—			
4	FOREIGN TRAVEL--			
5	Not covered by Medicare			
6	Medically necessary emer-			
7	gency care services begin-			
8	ning during the first 60			
9	days of each trip outside			
10	the USA			
11	First \$250 each calen-	\$0	\$0	\$250
12	dar year			
13	Remainder of Charges*	\$0	80% to a life-	20% and
14			time maximum	amounts over
15			benefit of	the \$50,000
16			\$50,000	lifetime
17				maximum
18				
19	—			
20	BASIC OUTPATIENT PRE-			
21	SCRIPTION DRUGS--			
22	Not covered by Medicare			
23	First \$250 each calendar	\$0	\$0	\$250
24	year			
25	Next \$2,500 each calendar	\$0	50%--\$1,250	50%
26	year		calendar year	
27			maximum	
28			benefit	
29	Over \$2,500 each calendar	\$0	\$0	All Costs
30	year			
31				

1 PLAN J OR HIGH DEDUCTIBLE PLAN J
 2 MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD
 3 *A benefit period begins on the first day you receive service as an
 4 inpa-
 5 tient in a hospital and ends after you have been out of the hospital and
 6 have not received skilled care in any other facility for 60 days in a
 7 row.
 8 **THIS HIGH DEDUCTIBLE PLAN PAYS THE SAME OR OFFERS THE SAME BENEFITS AS
 9 PLAN J AFTER YOU HAVE PAID A CALENDAR YEAR (\$1,580) DEDUCTIBLE.
 10 BENEFITS
 11 FROM THE HIGH DEDUCTIBLE PLAN J WILL NOT BEGIN UNTIL OUT-OF-POCKET
 12 EXPENSES ARE \$1,580. OUT-OF-POCKET EXPENSES FOR THIS DEDUCTIBLE ARE
 13 EXPENSES THAT WOULD ORDINARILY BE PAID BY THE POLICY. THIS INCLUDES
 14 MEDICARE DEDUCTIBLES FOR PART A AND PART B, BUT DOES NOT INCLUDE THE
 15 PLAN'S SEPARATE FOREIGN TRAVEL EMERGENCY DEDUCTIBLE.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$1,580 DEDUCTIBLE**,	IN ADDITION TO \$1,580
DEDUCTIBLE**,		PLAN PAYS	YOU PAY

HOSPITALIZATION* Semiprivate room and board, general nursing and mis- cellaneous services and supplies	All but -\$628- \$792	-\$628- \$792 (Part A Deductible)	\$0
First 60 days	All but -\$157- \$198 a day	-\$157- \$198 a day	\$0
61st thru 90th day 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

46 SKILLED NURSING FACILITY
 47 CARE*
 48 You must meet Medicare's
 49 requirements, including
 50 having been in a hospital
 51 for at least 3 days and

1	entered a Medicare-approved			
2	facility within 30 days			
3	after leaving the hospital			
4	First 20 days	All approved		
5		amounts	\$0	\$0
6	21st thru 100th day	All but	Up to	\$0
7		\$78.50	\$78.50	
8		\$99 a day	\$99 a day	
9	101st day and after	\$0	\$0	All costs
10				
11	—			
12	BLOOD			
13	First 3 pints	\$0	3 pints	\$0
14	Additional amounts	100%	\$0	\$0
15				
16	—			
17	HOSPICE CARE			
18	Available as long as your	All but very	\$0	Balance
19	doctor certifies you are	limited coinsurance		
20	terminally ill and you	for outpatient		
21	elect to receive these	drugs and inpatient		
22	services	respite care		
23				
	—			

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 DEDUCTIBLE**,	MEDICARE PAYS	AFTER YOU PAY \$1,580 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$1,580 YOU PAY
MEDICAL EXPENSES-- In or out of the hospital and outpatient hospital treatment, such as Physi- cian's services, inpatient and outpatient medical and surgical services and sup- plies, physical and speech therapy, diagnostic tests, 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 Next \$100 of Medicare Approved Amounts*	\$0	All Costs	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

1

2

—

3

CLINICAL LABORATORY

4

SERVICES--

5

Blood tests for diagnostic

6

services

100%

\$0

\$0

7

—

8

(continued)

PARTS A & B

1				
2				
3	—			
4	HOME HEALTH CARE			
5	Medicare Approved			
6	Services			
7	--Medically necessary			
8	skilled care services			
9	and medical supplies	100%	\$0	\$0
10	--Durable medical equip-			
11	ment			
12	First \$100 of Medicare			
13	Approved Amounts*	\$0	\$100 (Part B	\$0
14			Deductible)	
15	Remainder of Medicare			
16	Approved Amounts	80%	20%	\$0
17	AT-HOME RECOVERY			
18	SERVICES--			
19	Not covered by Medicare			
20	Home care certified by			
21	your doctor, for personal			
22	care beginning during			
23	recovery from an injury or			
24	sickness for which Medicare			
25	approved a Home Care Treat-			
26	ment Plan			
27	--Benefit for each visit	\$0	Actual Charges	Balance
28			to \$40 a visit	
29	--Number of visits cov-	\$0	Up to the num-	
30	ered (must be received		ber of Medicare	
31	within 8 weeks of last		Approved	
32	Medicare Approved		visits, not to	
33	visit)		exceed 7 each	
34			week	
35	--Calendar year maximum	\$0	\$1,600	
36				

37
(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-	\$0	\$0	\$250
dar year			
Remainder of Charges	\$0	80% to a life-	20% and
		time maximum	amounts over
		benefit of	the \$50,000
		\$50,000	lifetime
			maximum
—			
EXTENDED OUTPATIENT PRE-			
SCRIPTION DRUGS--			
Not covered by Medicare			
First \$250 each calendar	\$0	\$0	\$250
year			
Next \$6,000 each calendar	\$0	50%--\$3,000	50%
year		calendar year	
		maximum	
		benefit	
Over \$6,000 each calendar	\$0	\$0	All Costs
year			
—			
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	\$0	\$120	\$0
year			
Additional charges	\$0	\$0	All costs

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

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

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

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

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

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

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

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

12 (3) A medicare supplement policy shall provide that benefits
13 and premiums under the policy shall be suspended at the request
14 of the policyholder or certificate holder for a period not to
15 exceed 24 months in which the policyholder or certificate holder
16 has applied for and is determined to be entitled to medical
17 assistance under medicaid, but only if the policyholder or cer-
18 tificate holder notifies the insurer of such assistance within 90
19 days after the date the individual becomes entitled to the
20 assistance. Upon receipt of timely notice, the insurer shall
21 return to the policyholder or certificate holder that portion of
22 the premium attributable to the period of medicaid eligibility,
23 subject to adjustment for paid claims. If a suspension occurs
24 and if the policyholder or certificate holder loses entitlement
25 to medical assistance under medicaid, the policy shall be auto-
26 matically reinstituted effective as of the date of termination of
27 the assistance if the policyholder or certificate holder provides

1 notice of loss of medicaid medical assistance within 90 days
2 after the date of the loss and pays the premium attributable to
3 the period effective as of the date of termination of the
4 assistance. EACH MEDICARE SUPPLEMENT POLICY SHALL PROVIDE THAT
5 BENEFITS AND PREMIUMS UNDER THE POLICY SHALL BE SUSPENDED AT THE
6 REQUEST OF THE POLICYHOLDER IF THE POLICYHOLDER IS ENTITLED TO
7 BENEFITS UNDER SECTION 226(B) OF TITLE II OF THE SOCIAL SECURITY
8 ACT, AND IS COVERED UNDER A GROUP HEALTH PLAN AS DEFINED IN
9 SECTION 1862(B)(1)(A)(v) OF THE SOCIAL SECURITY ACT. IF SUSPEN-
10 SION OCCURS AND IF THE POLICYHOLDER OR CERTIFICATE HOLDER LOSES
11 COVERAGE UNDER THE GROUP HEALTH PLAN, THE POLICY SHALL BE AUTO-
12 MATICALLY REINSTITUTED EFFECTIVE AS OF THE DATE OF LOSS OF COVER-
13 AGE IF THE POLICYHOLDER PROVIDES NOTICE OF LOSS OF COVERAGE
14 WITHIN 90 DAYS AFTER THE DATE OF THE LOSS AND PAYS THE PREMIUM
15 ATTRIBUTABLE TO THE PERIOD, EFFECTIVE AS OF THE DATE OF TERMINA-
16 TION OF ENROLLMENT IN THE GROUP HEALTH PLAN. All of the following
17 apply to the reinstitution of a medicare supplement policy under
18 this subsection:

19 (A) ~~-(i)-~~ The reinstitution shall not provide for any wait-
20 ing period with respect to treatment of preexisting conditions.

21 (B) ~~-(ii)-~~ Reinstated coverage shall be substantially
22 equivalent to coverage in effect before the date of the
23 suspension.

24 (C) ~~-(iii)-~~ Classification of premiums for reinstated cov-
25 erage shall be on terms at least as favorable to the policyholder
26 or certificate holder as the premium classification terms that

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

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

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

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

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

9 (A) ONE OR MORE OF THE FOLLOWING:

10 (i) COVERAGE ONLY FOR ACCIDENT OR DISABILITY INCOME INSUR-
11 ANCE, OR ANY COMBINATION OF ACCIDENT OR DISABILITY INCOME
12 INSURANCE.

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

15 (iii) LIABILITY INSURANCE, INCLUDING GENERAL LIABILITY
16 INSURANCE AND AUTOMOBILE LIABILITY INSURANCE.

17 (iv) WORKERS' COMPENSATION OR SIMILAR INSURANCE.

18 (v) AUTOMOBILE MEDICAL PAYMENT INSURANCE.

19 (vi) CREDIT-ONLY INSURANCE.

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

21 (viii) OTHER SIMILAR INSURANCE COVERAGE, SPECIFIED IN FED-
22 ERAL REGULATIONS, UNDER WHICH BENEFITS FOR MEDICAL CARE ARE SEC-
23 ONDARY OR INCIDENTAL TO OTHER INSURANCE BENEFITS.

24 (B) THE FOLLOWING BENEFITS IF THEY ARE PROVIDED UNDER A SEP-
25 ARATE POLICY, CERTIFICATE, OR CONTRACT OF INSURANCE OR ARE OTHER-
26 WISE NOT AN INTEGRAL PART OF THE PLAN:

1 (i) LIMITED SCOPE DENTAL OR VISION BENEFITS.

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

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

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

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

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

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

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

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

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

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

1 SUPPLEMENT POLICY DESCRIBED IN SUBSECTIONS (5), (6), AND (7) THAT
2 IS OFFERED AND IS AVAILABLE FOR ISSUANCE TO NEW ENROLLEES BY THE
3 INSURER, SHALL NOT DISCRIMINATE IN THE PRICING OF THE MEDICARE
4 SUPPLEMENT POLICY BECAUSE OF HEALTH STATUS, CLAIMS EXPERIENCE,
5 RECEIPT OF HEALTH CARE, OR MEDICAL CONDITION, AND SHALL NOT
6 IMPOSE AN EXCLUSION OF BENEFITS BASED ON A PREEXISTING CONDITION
7 UNDER THE MEDICARE SUPPLEMENT POLICY.

8 (2) AN ELIGIBLE PERSON UNDER THIS SECTION IS AN INDIVIDUAL
9 THAT MEETS ANY OF THE FOLLOWING:

10 (A) IS ENROLLED UNDER AN EMPLOYEE WELFARE BENEFIT PLAN THAT
11 PROVIDES HEALTH BENEFITS THAT SUPPLEMENT THE BENEFITS UNDER MEDI-
12 CARE AND THE PLAN TERMINATES OR THE PLAN CEASES TO PROVIDE ALL
13 THOSE SUPPLEMENTAL HEALTH BENEFITS TO THE INDIVIDUAL.

14 (B) IS ENROLLED WITH A MEDICARE+CHOICE ORGANIZATION UNDER A
15 MEDICARE+CHOICE PLAN UNDER PART C OF MEDICARE, AND ANY OF THE
16 FOLLOWING CIRCUMSTANCES APPLY, OR THE INDIVIDUAL IS 65 YEARS OF
17 AGE OR OLDER AND IS ENROLLED WITH A PACE PROVIDER UNDER
18 SECTION 1894 OF THE SOCIAL SECURITY ACT, AND THERE ARE CIRCUM-
19 STANCES SIMILAR TO THOSE DESCRIBED BELOW THAT WOULD PERMIT DIS-
20 CONTINUANCE OF THE INDIVIDUAL'S ENROLLMENT WITH THE PROVIDER IF
21 THE INDIVIDUAL WERE ENROLLED IN A MEDICARE+CHOICE PLAN:

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

24 (ii) THE ORGANIZATION HAS TERMINATED OR OTHERWISE DISCONTIN-
25 UED PROVIDING THE PLAN IN THE AREA IN WHICH THE INDIVIDUAL
26 RESIDES.

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

10 (iv) THE INDIVIDUAL DEMONSTRATES, IN ACCORDANCE WITH GUIDE-
11 LINES ESTABLISHED BY THE SECRETARY, THAT THE ORGANIZATION OFFER-
12 ING THE PLAN SUBSTANTIALLY VIOLATED A MATERIAL PROVISION OF THE
13 ORGANIZATION'S CONTRACT IN RELATION TO THE INDIVIDUAL, INCLUDING
14 THE FAILURE TO PROVIDE AN ENROLLEE ON A TIMELY BASIS MEDICALLY
15 NECESSARY CARE FOR WHICH BENEFITS ARE AVAILABLE UNDER THE PLAN OR
16 THE FAILURE TO PROVIDE COVERED CARE IN ACCORDANCE WITH APPLICABLE
17 QUALITY STANDARDS, OR THE ORGANIZATION, OR AGENT OR OTHER ENTITY
18 ACTING ON THE ORGANIZATION'S BEHALF, MATERIALLY MISREPRESENTED
19 THE PLAN'S PROVISIONS IN MARKETING THE PLAN TO THE INDIVIDUAL.

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

22 (C) IS ENROLLED WITH AN ELIGIBLE ORGANIZATION UNDER A CON-
23 TRACT UNDER SECTION 1876 OF THE SOCIAL SECURITY ACT, A SIMILAR
24 ORGANIZATION OPERATING UNDER DEMONSTRATION PROJECT AUTHORITY,
25 EFFECTIVE FOR PERIODS BEFORE APRIL 1, 1999, AN ORGANIZATION UNDER
26 AN AGREEMENT UNDER SECTION 1833(A)(1)(A) OF THE SOCIAL SECURITY
27 ACT, HEALTH CARE PREPAYMENT PLAN, OR AN ORGANIZATION UNDER A

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

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

6 (i) THE INSOLVENCY OF THE INSURER OR BANKRUPTCY OF THE NON-
7 INSURER ORGANIZATION OR OF OTHER INVOLUNTARY TERMINATION OF COV-
8 ERAGE OR ENROLLMENT UNDER THE POLICY.

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

11 (iii) THE INSURER, OR AN AGENT OR OTHER ENTITY ACTING ON THE
12 INSURER'S BEHALF, MATERIALLY MISREPRESENTED THE POLICY'S PROVI-
13 SIONS IN MARKETING THE POLICY TO THE INDIVIDUAL.

14 (E) WAS ENROLLED UNDER A MEDICARE SUPPLEMENT POLICY AND TER-
15 MINATES ENROLLMENT AND SUBSEQUENTLY ENROLLS, FOR THE FIRST TIME,
16 WITH ANY MEDICARE+CHOICE ORGANIZATION UNDER A MEDICARE+CHOICE
17 PLAN UNDER PART C OF MEDICARE, ANY ELIGIBLE ORGANIZATION UNDER A
18 CONTRACT UNDER SECTION 1876 OF THE SOCIAL SECURITY ACT, MEDICARE
19 COST, ANY SIMILAR ORGANIZATION OPERATING UNDER DEMONSTRATION
20 PROJECT AUTHORITY, ANY PACE PROVIDER UNDER SECTION 1894 OF THE
21 SOCIAL SECURITY ACT, OR A MEDICARE SELECT POLICY; AND THE SUBSE-
22 QUENT ENROLLMENT IS TERMINATED BY THE ENROLLEE DURING ANY PERIOD
23 WITHIN THE FIRST 12 MONTHS OF THE SUBSEQUENT ENROLLMENT DURING
24 WHICH THE ENROLLEE IS PERMITTED TO TERMINATE THE SUBSEQUENT
25 ENROLLMENT UNDER SECTION 1851(E) OF THE SOCIAL SECURITY ACT.

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

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

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

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

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

18 (C) FOR AN INDIVIDUAL DESCRIBED IN SUBSECTION (2)(D)(i), THE
19 GUARANTEED ISSUE TIME PERIOD BEGINS ON THE EARLIER OF THE DATE
20 THAT THE INDIVIDUAL RECEIVES A NOTICE OF TERMINATION, A NOTICE OF
21 THE ISSUER'S BANKRUPTCY OR INSOLVENCY, OR OTHER SUCH SIMILAR
22 NOTICE, IF ANY, OR THE DATE THAT THE APPLICABLE COVERAGE IS TER-
23 MINATED, AND ENDS ON THE DATE THAT IS 63 DAYS AFTER THE DATE THE
24 COVERAGE IS TERMINATED.

25 (D) FOR AN INDIVIDUAL DESCRIBED IN SUBSECTION (2)(B),
26 (D)(ii), (D)(iii), (E), OR (F) WHO DISENROLLS VOLUNTARILY, THE
27 GUARANTEED ISSUE TIME PERIOD BEGINS ON THE DATE THAT IS 60 DAYS

1 BEFORE THE EFFECTIVE DATE OF THE DISENROLLMENT AND ENDS ON THE
2 DATE THAT IS 63 DAYS AFTER THE EFFECTIVE DATE.

3 (E) FOR AN INDIVIDUAL DESCRIBED IN SUBSECTION (2) BUT NOT
4 DESCRIBED IN SUBDIVISIONS (A) TO (D), THE GUARANTEED ISSUE TIME
5 PERIOD BEGINS ON THE EFFECTIVE DATE OF DISENROLLMENT AND ENDS ON
6 THE DATE THAT IS 63 DAYS AFTER THE EFFECTIVE DATE.

7 (4) FOR AN INDIVIDUAL DESCRIBED IN SUBSECTION (2)(E) WHOSE
8 ENROLLMENT WITH AN ORGANIZATION OR PROVIDER DESCRIBED IN SUBSEC-
9 TION (2)(E) IS INVOLUNTARILY TERMINATED WITHIN THE FIRST 12
10 MONTHS OF ENROLLMENT, AND WHO, WITHOUT AN INTERVENING ENROLLMENT,
11 ENROLLS WITH ANOTHER SUCH ORGANIZATION OR PROVIDER, THE SUBSE-
12 QUENT ENROLLMENT SHALL BE CONSIDERED AN INITIAL ENROLLMENT
13 DESCRIBED IN SUBSECTION (2)(E). FOR AN INDIVIDUAL DESCRIBED IN
14 SUBSECTION (2)(F) WHOSE ENROLLMENT WITHIN A PLAN OR IN A PROGRAM
15 DESCRIBED IN SUBSECTION (2)(F) IS INVOLUNTARILY TERMINATED WITHIN
16 THE FIRST 12 MONTHS OF ENROLLMENT, AND WHO, WITHOUT AN INTERVEN-
17 ING ENROLLMENT, ENROLLS IN ANOTHER SUCH PLAN OR PROGRAM, THE SUB-
18 SEQUENT ENROLLMENT SHALL BE CONSIDERED AN INITIAL ENROLLMENT
19 DESCRIBED IN SUBSECTION (2)(F). FOR PURPOSES OF SUBSECTIONS
20 (2)(E) AND (F), AN ENROLLMENT OF AN INDIVIDUAL WITH AN ORGANIZA-
21 TION OR PROVIDER DESCRIBED IN SUBSECTION (2)(E), OR WITH A PLAN
22 OR PROVIDER DESCRIBED IN SUBSECTION (2)(F), SHALL NOT BE CONSID-
23 ERED TO BE AN INITIAL ENROLLMENT AFTER THE 2-YEAR PERIOD BEGIN-
24 NING ON THE DATE ON WHICH THE INDIVIDUAL FIRST ENROLLED WITH SUCH
25 AN ORGANIZATION, PROVIDER, OR PLAN.

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

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

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

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

11 SEC. 3830A. (1) AT THE TIME OF AN EVENT DESCRIBED IN
12 SECTION 3830(2) BECAUSE OF WHICH AN INDIVIDUAL LOSES COVERAGE OR
13 BENEFITS DUE TO THE TERMINATION OF A CONTRACT OR AGREEMENT,
14 POLICY, OR PLAN, THE ORGANIZATION THAT TERMINATES THE CONTRACT OR
15 AGREEMENT, THE INSURER TERMINATING THE POLICY, OR THE ADMINISTRA-
16 TOR OF THE PLAN BEING TERMINATED, RESPECTIVELY, SHALL NOTIFY THE
17 INDIVIDUAL OF HIS OR HER RIGHTS UNDER SECTION 3830 AND OF THE
18 OBLIGATIONS OF INSURERS OF MEDICARE SUPPLEMENT POLICIES UNDER
19 SECTION 3830(1). THE NOTICE SHALL BE COMMUNICATED CONTEMPORANE-
20 OUSLY WITH THE NOTIFICATION OF TERMINATION.

21 (2) AT THE TIME OF AN EVENT DESCRIBED IN SECTION 3830(2)
22 BECAUSE OF WHICH AN INDIVIDUAL CEASES ENROLLMENT UNDER A CONTRACT
23 OR AGREEMENT, POLICY, OR PLAN, THE ORGANIZATION THAT OFFERS THE
24 CONTRACT OR AGREEMENT, REGARDLESS OF THE BASIS FOR THE CESSATION
25 OF ENROLLMENT, THE INSURER OFFERING THE POLICY, OR THE ADMINIS-
26 TRATOR OF THE PLAN, RESPECTIVELY, SHALL NOTIFY THE INDIVIDUAL OF
27 HIS OR HER RIGHTS UNDER SECTION 3830 AND OF THE OBLIGATIONS OF

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