

**TITLE 365. INSURANCE DEPARTMENT
CHAPTER 10. LIFE, ACCIDENT AND HEALTH**

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1.	General Provisions
Part 1.	General Provisions
365:10-1-6.	Oklahoma Life and Health Insurance Guaranty Association disclaimer notice requirements [AMENDED]
365:10-1-13.	Notification required upon rejection [AMENDED]
365:10-1-15	Eliminating unfair discrimination on basis of children as single applicants [NEW]
Subchapter 5.	Minimum Standards; Contract Guidelines
Part 1.	Minimum Standards and Benefits for Accident and Health Insurance
365:10-5-4.	Prohibited policy provisions [AMENDED]
Part 13.	Medicare Supplement Insurance Minimum Standards
365:10-5-128.2.	Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates issued for delivery on or after June 1, 2010 [AMENDED]
365:10-5-134.	Required disclosure provisions [AMENDED]
Appendix S.	Outline of Coverage [REVOKED]

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n/a

ANALYSIS:

The amendment to 365:10-1-6 updates language for the notice requirements for coverage or non-coverage by the Oklahoma Life and Health Insurance Guaranty Association Act as a result of the enactment of changes to the Oklahoma Life and Health Insurance Guaranty Association Act in Senate Bill 2043.

The amendment to 365:10-1-13 provides updated contact information for the Oklahoma Health Insurance High Risk Pool and Oklahoma Temporary High Risk Pool which must be contained in a notice of rejection of health insurance coverage.

New Section 365:10-1-15 requires insurers issuing individual accident and health policies within the state to have an open enrollment period for children under the age of 19. The section requires insurers to offer an open enrollment period from September 1 through October 31 for the year 2011 and for every year thereafter, from June 1 through July 31. Insurers must issue the child only policy on a guaranteed issue basis. Insurers may be subject to an administrative hearing and penalty for violating the section.

The amendment to 365:10-5-4 adds limited benefit insurance policies to the provision regarding policy limits and exclusions to further clarify to which types of policies the paragraph applies. The amendment to 365:10-5-128.2 removes the 150 days hospitalization requirement and replaces it with the hospitalization after the lifetime reserves days are exhausted.

The amendment to 365:10-5-134 removes references to Appendix S and replaces it with language referring to the most recent edition of the NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act. This eliminates confusion as to which outline of coverage insurers shall use when dealing with Medicare Supplement Benefit Plans.

Appendix S is revoked because it is not the current outline of coverage required by the NAIC to be utilized by insurers. Additionally, amendments to 365:10-5-134 encompass the needed reference to the most recent outline of coverage as promulgated by the NAIC.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 14, 2011:

SUBCHAPTER 1. GENERAL PROVISIONS

PART 1. GENERAL PROVISIONS

365:10-1-6. Oklahoma Life and Health Insurance Guaranty Association ~~disclaimer~~ notice requirements

(a) **Purpose.** The purpose of this section is to provide the contract or policyholders with information concerning the coverage or non-coverage by the Oklahoma Life and Health Insurance Guaranty Association Act.

(b) **~~Disclaimer.~~ Form of notice.** The notice for policies or contracts covered or not covered by the Guaranty Association shall be prepared as follows:

(1) The ~~disclaimer~~ information required by 36 O.S. (~~Supp.1988~~) Section 2043(C) shall be ~~printed in bold fact type and included on the fact page of the summary document required by 36 O.S. (~~Supp.1988~~) Section 2043(B).~~ The ~~disclaimer shall be entitled "Disclaimer", and summary document shall contain the following statements:~~

(A) Prominently warn the policy or contract holder that the Life and Health Insurance Guaranty Association may not cover the policy or, if coverage is available, it will be subject to substantial limitations, exclusions and conditioned on continued residence in the state;

(B) State that the insurer and its agents are prohibited by law from using the existence of the Life and Health Insurance Guaranty Association for the purpose of sales, solicitation or inducement to purchase any form of insurance;

(C) Emphasize that the policy or contract holder should not rely on coverage under the Life and Health Insurance Guaranty Association when selecting an insurer; and

(D) State the name and address of the Life and Health Insurance Guaranty Association and Insurance Department.

(2) The Oklahoma Life and Health Insurance Guaranty Association shall prepare and submit to the Commissioner for the Insurance Commissioner's approval the ~~"Disclaimer" and "Summary Document"~~ document required by (1) of this subsection. If the Guaranty Association fails to submit a ~~Disclaimer document~~ that meets with the Commissioner's approval within 30 days after this section is adopted the National Association of Insurance Commissioner Model ~~Disclaimer Notice~~ shall be used.

(3) The notice required by 36 O.S. (~~Supp.1988~~) Section 2043(D) shall be printed in bold fact type on a separate one page document, not less than eight inches by five inches, with type not less than 10-point. The notice shall be entitled, "Special Notice", and shall contain the following information:

(A) Company name and address;

(B) A statement disclosing that all or a portion of the policy or contract is not guaranteed by the insurer or all or a portion of the risk under the policy or contract

is borne by the policy or contract holder and is not covered by the Oklahoma Life and Health Insurance Guaranty Association; and

(C) The statements required by (1)(B) and (1)(D) of this subsection.

(c) **Separability provision.** If any provision of this section or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the section and the application of such provisions to the persons or circumstances shall not be affected thereby.

365:10-1-13. Notification required upon rejection

In the event an insurer rejects an applicant seeking health insurance coverage, such rejection shall be in writing and shall state with specificity the reason(s) for the denial. The rejection notification shall ~~further advise the applicant of the availability of the Oklahoma Health Insurance High Risk Pool and its toll free telephone number in the following format: For more information regarding this alternative please call 1-877-793-6477. You may also want to visit the website of the Oklahoma Health Insurance High Risk Pool at www.okhrp.org.~~ contain the following language: "Although your application for health insurance coverage was rejected, you may be eligible for coverage through the Oklahoma Health Insurance High Risk Pool or the Oklahoma Temporary High Risk Pool. For more information regarding these alternatives, please call 1-877-885-3717 or access the website at www.bcbsok.com/ohrp."

365:10-1-15. Eliminating unfair discrimination on basis of children as single applicants

(a) **Purpose.** The purpose of this section is to eliminate the act of denying benefits or coverage unfairly in the issuance, terms and conditions of insurance contracts and in underwriting criteria of insurance carriers. It is not intended to prohibit reasonable and justifiable differences in premium rates based upon sound actuarial principles or actual or reasonably anticipated experience.

(b) **Definitions.**

(1) "Child only policy" means an individual health benefit policy, which provides coverage to an individual under the age of nineteen (19). This shall not include health benefit policies that cover children under the age of nineteen (19) as a dependent;

(2) "Insurer" includes:

(A) every person engaged in the business of making contracts of insurance or indemnity,

(B) a nonprofit hospital service and medical indemnity corporation, and

(C) a health maintenance organization.

(3) "Qualifying event" includes birth, adoption, or an involuntary loss of coverage due to marriage of a child's parent, dissolution of a parent's marriage, death of a parent, loss of employer-sponsored insurance, loss of eligibility under the Oklahoma Medicaid Program, including loss of eligibility in the SoonerCare or SoonerStart programs, 56 O.S. §§ 1010.1 through 1010.13 and 1011.1 through 1011.11, entry of a valid court order mandating the child be covered, or loss of other existing coverage for any reason other than fraud, misrepresentation or failure to pay premium.

(c) **Enrollment.**

(1) Enrollment only allowed during certain periods.

(A) Insurers issuing child only policies on or after September 23, 2010 shall only accept applications for coverage during the open enrollment periods outlined in this section or during the 30 day period following a qualifying event.

(B) Enrollment outside the open enrollment periods shall be prohibited, except upon the occurrence of a qualifying event.

(2) For the year 2011, insurers offering child only policies shall hold an open enrollment period from September 1 through October 31. During this open enrollment period, all children under the age of nineteen (19) shall be offered coverage on a guaranteed issue basis, without any limitations or riders based on health status. Insurers shall use such rates as have been filed and approved by the Insurance Commissioner.

(3) Beginning January 1, 2012, insurers offering child only policies shall hold an open enrollment period from June 1 through July 31 of each year. During these open enrollment periods, all children under the age of nineteen (19) shall be offered coverage on a guaranteed issue basis, without any limitations or riders based on health status. Insurers shall use such rates as have been filed and approved by the Insurance Commissioner.

(4) Notice of the open enrollment opportunity and open enrollment dates for new applicants, as well as the opportunity to enroll due to a qualifying event, shall be displayed prominently on the insurer's website throughout the year.

(5) Applications for coverage during an open enrollment period shall become effective on the first day of the month following receipt of the completed application, except that if mutually agreed upon by the applicant and the insurer an alternative effective date may be selected.

(6) Nothing contained in this section shall alter the ability of an applicant to obtain a child only policy outside the open enrollment period upon the occurrence of a qualifying event.

(e) **Insurer participation.** Only insurers that participate in the most recent open enrollment period shall be permitted to write child only policies. Any insurer not participating in the most recent open enrollment period shall be prohibited from issuing child only policies until the commencement of the next subsequent open enrollment period, regardless of whether the policy is issued as a result of a qualifying event.

(f) **Penalty for violations.** Noncompliance with this section may result, after proper notice and hearing, in an administrative action and penalty.

SUBCHAPTER 5. MINIMUM STANDARDS; CONTRACT GUIDELINES

PART 1. MINIMUM STANDARDS AND BENEFITS FOR ACCIDENT AND HEALTH INSURANCE

365:10-5-4. Prohibited policy provisions

(a) **Probationary or waiting period.** Except as provided in 365:10-5-3(6), no policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy, subject to the further exception that a policy may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting therefrom, for hernia, disorder of reproduction organs, varicose veins, exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

(b) **Policy or rider for dividend.** No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to such dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than 6 months. The initial renewal subsequent to the issuance of any policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that such renewal is optional with the policyholder.

(c) **Pre-existing conditions.** No policy shall exclude coverage for a loss due to a pre-existing condition or a period greater than 12 months following policy issue where the application for such insurance does not seek disclosure of prior illness, disease or physical condition or prior medical care and treatment and such pre-existing condition is not specifically excluded by the terms of the policy.

(d) **Hospital confinement indemnity coverage.** Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

(e) **Policy limits or exclusions, Exceptions.** No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

(1) Pre-existing conditions or diseases, except for congenital anomalies of a covered dependent child. This paragraph shall apply to:

(A) policies of accident and health insurance, and

(B) limited benefit insurance policies;

(2) Mental or emotional disorders, alcoholism and drug addiction;

(3) Pregnancy, except for complications of pregnancy, other than for policies defined in 365:10-5-5(g);

(4) Illness, treatment or medical condition arising out of:

(A) war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer; participation in a felony, riot or insurrections, service in the armed forces or units auxiliary thereto;

(B) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

- (C) aviation;
- (D) with respect to short-term non-renewable policies, interscholastic sports;
- (5) cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted, if a functional defect;
- (6) foot care in connection with corns, calluses, flat feet, fallen arches, weak fee, chronic foot strain, or symptomatic complaint of the feet;
- (7) treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employers liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;
- (8) dental care or treatment;
- (9) eye glasses, hearing aids and examination for the prescription or fitting thereof;
- (10) rest cures, custodial care, transportation and routine physical examinations;
- (11) territorial limitations;
- (12) cost containment:
 - (A) pre-admission certification;
 - (B) second surgical opinion and third surgical opinion if the first two conflict;
 - (C) one-hundred percent coverage for generic drugs while hospital confined, or on a physician's prescription;
 - (D) insured self audit of hospital bills.

(f) **Use of waiver.** Except with respect to Medicare Supplement Coverages as defined in 365:10-5-5(b), other provisions of this section shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described pre-existing diseases, physical condition or extra hazardous activity, where waivers are required as a condition or issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page. Waivers to exclude, limit or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions shall not be used in Medicare Supplement Coverages.

(g) **Use of the terms "Medicare Supplement" and "Medigap".** Except as otherwise provided in 365:10-5-6(a)(11) the terms "Medicare Supplement", "Medigap" and words of similar import shall not be used unless the policy is issued in compliance with 365:10-5-5(b).

(h) **Policy provisions.** Policy provisions precluded in this section shall not be constructed as a limitation on the authority of the Commissioner to disapprove other policy provisions which, in the opinion of the Commissioner, are unjust, unfair, or unfairly discriminatory to the

policyholder, beneficiary, or any person insured under the policy, pursuant to the Oklahoma Insurance Code.

(i) **Policy limitations.** A policy issued as a "Medicare Supplement Coverage" pursuant to 365:10-5-5(b) shall not include, when issued, limitations or exclusions of the type enumerated in 365:10-5-4(e)(6), (7), (11) and (12) if such limitations or exclusions are more restrictive than those of Medicare for any type of care covered under such policy.

PART 13. MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

365:10-5-128.2. Standard Medicare supplement benefit plans for 2010 standardized Medicare supplement benefit plan policies or certificates issued for delivery on or after June 1, 2010

(a) The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of O.A.C. 365:10-5-126 and 365:10-5-127.

(b) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic (core) benefits, as defined in O.A.C. 365:10-5-127.1. If an issuer makes available any of the additional benefits described in O.A.C. 365:10-5-127.1(d), or offers standardized benefit Plans K or L (as described in O.A.C. 365:10-5-128.3(f)(8) and (9)), then the issuer shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic (core) benefits as described above, a policy form or certificate form containing either standardized benefit Plan C (as described in O.A.C. 365:10-5-128.2(f)(3)) or standardized benefit Plan F (as described in O.A.C. 365:10-5-128.2(f)(5)).

(c) No groups, packages or combinations of Medicare supplement benefits other than those listed in this Section shall be offered for sale in this state, except as may be permitted in O.A.C. 365:10-5-128.2(g) and in O.A.C. 365:10-5-128.3.

(d) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this Subsection and conform to the definitions in O.A.C. 365:10-5-123. Each benefit shall be structured in accordance with the format provided in O.A.C. 365:10-5-127.1(c) and (d); or, in the case of plans K or L, in O.A.C. 365:10-5-128.2(f)(8) or (9) of this regulation and list the benefits in the order shown. For purposes of this Section, "structure, language, and format" means style, arrangement and overall content of a benefit.

(e) In addition to the benefit plan designations required in Subsection (d) of this section, an issuer may use other designations to the extent permitted by law.

(f) Make-up of 2010 Standardized Benefit Plans:

(1) Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in O.A.C. 365:10-5-127.1(c).

(2) Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in Section of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible as defined in 365:10-5-127.1(d)(1).

(3) Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in O.A.C. 365:10-5-127.1(c), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in O.A.C. 365:10-5-127.1(d)(1), (3), (4), and (6), respectively.

(4) Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit (as defined in O.A.C. 365:10-5-127.1(c), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in an foreign country as defined in O.A.C. 365:10-5-127.1(d) (1), (3), and (6), respectively.

(5) Standardized Medicare supplement [regular] Plan F shall include only the following:

The basic (core) benefit as defined in O.A.C. 365:10-5-127.1(c), plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in O.A.C. 365:10-5-127.1(d) (1), (3), (4), (5), and (6).

(6) Standardized Medicare supplement Plan F With High Deductible shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in Subparagraph (b).

(A) The basic (core) benefit as defined in 365:10-5-127.1(c), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in 365:10-5-127.1(d) (1), (3), (4), (5), and (6).

(B) The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by regular Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be \$1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10).

(7) Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in 365:10-5-127.1(c), plus one hundred

percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in 365:10-5-127.1(d) (1), (3), (5), and (6), respectively.

(8) Standardized Medicare supplement Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(A) Part A Hospital Coinsurance 61st through 90th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(B) Part A Hospital Coinsurance, 91st through 150th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(C) Part A Hospitalization After ~~150 Days~~ Lifetime Reserve Days are Exhausted: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(D) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (x);

(E) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (x);

(F) Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph (x);

(G) Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph (x);

(H) Part B Cost Sharing: Except for coverage provided in Subparagraph (ix), coverage for fifty percent (50%) of the cost sharing otherwise applicable under

Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph (x);

(I) Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(J) Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of \$4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(9) Standardized Medicare supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(A) The benefits described in 365:10-5-128.2(f)(8)(A), (B), (C) and (I);

(B) The benefit described in 365:10-5-128.2(f)(8)(D), (E), (F), (G) and (H), but substituting seventy-five percent (75%) for fifty percent (50%); and

(C) The benefit described in 365:10-5-128.2(f)(8)(J), but substituting \$2000 for \$4000.

(10) Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in 365:10-5-127.1(c), plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in 365:10-5-127.1(d)(2), (3) and (6).

(11) Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in 365:10-5-127.1(c), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in 365:10-5-127.1(cd)(1), (3) and (6), with copayments in the following amounts:

(A) the lesser of twenty dollars (\$20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and

(B) the lesser of fifty dollars (\$50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(g) New or Innovative Benefits: An issuer may, with the prior approval of the Commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare

supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

365:10-5-134. Required disclosure provisions

(a) **General rules.**

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision shall be consistent with the type of contract issued. Such provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

(3) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6) If the issuer does not return any premiums or moneys paid therefor within thirty (30) days from the date of cancellation, the issuer shall pay interest on the proceeds which shall be the same rate of interest as the average United States Treasury Bill rate of the preceding calendar year as certified to the State Insurance Commissioner by the State Treasurer on the first regular business day in January of each year, plus two percentage

points which shall accrue from the date of cancellation until the premiums or moneys are returned. In such event, the policy shall be deemed to have been cancelled on the date the policy was placed in the United States mails in a properly addressed, postage paid envelope; or, if not so posted, on the date of delivery of such policy to the issuer.

(7) Issuers of accident and health policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis, to a person(s) eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the CMS and in a type size no smaller than 12 point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this Part. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered. For purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(b) **Notice requirements.**

(1) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the Commissioner. Such notice shall:

(A) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and

(B) Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

(2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) Such notices shall not contain or be accompanied by any solicitation.

(c) **MMA notice requirements.** Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

(d) **Outline of coverage requirements for Medicare supplement policies.**

(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of such outline from the applicant.

(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 which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve (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) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed in ~~Appendix S of this Chapter~~ the most recent edition of the National Association of Insurance Commissioners (NAIC) Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act in no less than twelve (12) point type. All plans shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(4) The outline of coverage shall include the items described in ~~Appendix S of this Chapter~~ the most recent edition of the NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, in the order prescribed by ~~Appendix S~~ the most recent edition of the NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act. The appropriate version of the outline of coverage as set out in ~~Appendix S~~ the model act shall be used.

(e) **Notice regarding policies or certificates which are not Medicare supplement policies.**

(1) Any accident and health insurance policy or certificate, other than a Medicare supplement policy, a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. § 1395 et seq.), disability income policy, or other policy identified in 365:10-5-122(b), issued for delivery in this State to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Subsection (d)(1) of this Section shall disclose, using the applicable statement in Appendix V, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

**APPENDIX S. OUTLINE OF COVERAGE
TABLE 1. OUTLINE OF COVERAGE - COVER PAGE [REVOKED]**

[COMPANY NAME]

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

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

See Outlines of Coverage sections for details about ALL plans

BASIC BENEFITS for plans A – J:

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

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), or copayments for hospital outpatient services.

Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance		Skilled Nursing Facility Co-Insurance				
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible				
		Part B Deductible			Part B Deductible						Part B Deductible
					Part B Excess		Part B Excess (80%)		Part B Excess		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency				
			At-Home Recovery				At-Home Recovery		At-Home Recovery		At-Home Recovery
				Preventive Care NOT covered by Medicare							Preventive Care NOT covered by Medicare

*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year [\$1730] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are [\$1730]. Out-of-pocket expenses for this

deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

[COMPANY NAME]
Outline of Medicare Supplement Coverage-Cover Page 2

Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	[\$4000] Out of Pocket Annual Limit***	[\$2000] Out of Pocket Annual Limit***

**** Plans K and L provide for different cost-sharing for items and services than Plans A – J.**

Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges”. You will be responsible for paying excess charges.

*****The out-of-pocket annual limit will increase each year for inflation.**

See Outlines of Coverage for details and exception.

**OUTLINE OF COVERAGE
TABLE 2. REQUIRED ITEMS**

PREMIUM INFORMATION [Boldface Type]

We [insert issuer'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 [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

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 [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer'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 [Boldface Type]

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 [Boldface Type]

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

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company'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 "Medicare and You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

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 prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to 365:10-5-128(d).]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Commissioner.]

OUTLINE OF COVERAGE
TABLE 3. PLAN A
MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive services 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 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[0] \$[228] a day \$[456] a day 100% of Medicare Eligible Expenses \$[0]	\$[912] (Part A Deductible) \$[0] \$[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 21st thru 100th days 101st day and after	All approved amounts All but \$[114] a day \$[0]	\$[0] \$[0] \$[0]	\$[0] Up to \$ [114] a day All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[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 co-insurance for outpatient drugs and inpatient respite care	\$[0]	Balance
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****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN A
MEDICARE (PART B)--MEDICAL SERVICES--PER CALENDAR YEAR**

*Once you have been billed \$[100] of Medicare- 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 OUR 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* Remainder of Medicare Approved Amounts	\$[0] 80% (Generally)	\$[0] 20% (Generally)	\$[100] (Part B Deductible) \$[0]
Part B Excess Charges (Above Medicare Approved Amounts)	\$[0]	\$[0]	All Costs
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[100] (Part B Deductible) \$[0]
CLINICAL LABORATORY SERVICES-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

PARTS A & B

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$[0] 80%	\$[0] \$[0] 20%	\$[0] \$[100] (Part B Deductible) \$[0]

OUTLINE OF COVERAGE
TABLE 4. PLAN B
MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive services 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 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[912] (Part A Deductible) \$[228] a day \$[456] a day 100% of Medicare Eligible Expenses \$[0]	\$[0] \$[0] \$[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 21st thru 100th days 101st day and after	All approved amounts All but \$[100] a day \$[0]	\$[0] \$[0] \$[0]	\$[0] Up to \$ [100] a day All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[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 co-insurance for outpatient drugs and inpatient respite care	\$[0]	Balance
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****NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

**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 OUR 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% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			

MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$[0]	\$[0]
--Durable medical equipment First \$[110] of Medicare Approved Amounts*	\$[0]	\$[0]	\$[110] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$[0]

OUTLINE OF COVERAGE
TABLE 5. PLAN C
MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive services 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 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve dates are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[912] (Part A Deductible) \$[228] a day \$[456] a day 100% of Medicare Eligible Expenses \$[0]	\$[0] \$[0] \$[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 21st thru 100th days 101st day and after	All approved amounts All but \$[114] a day \$[0]	\$[0] \$[0] \$[0]	\$[0] Up to \$ [114] a day All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[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 co-insurance for outpatient drugs and inpatient respite care	\$[0]	Balance
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****NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

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 OUR 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% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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]

(continued)

Plan C
(continued)

OTHER BENEFITS--NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 Remainder of Charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum of \$[50,000]	\$[250] 20% of amounts over the \$[50,000] lifetime maximum

OUTLINE OF COVERAGE
TABLE 6. PLAN D
MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive services 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 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve dates are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[912] (Part A Deductible) \$[228] a day \$[456] a day 100% of Medicare Eligible Expenses \$[0]	\$[0] \$[0] \$[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 21st thru 100th days 101st day and after	All approved amounts All but \$[114] a day \$[0]	\$[0] Up to \$[114] a day \$[0]	\$[0] \$ [0] All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[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 co-insurance for outpatient drugs and inpatient respite care	\$[0]	Balance
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****NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

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 OUR 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% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

**Plan D
(continued)
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts</p> <p>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 Home Care Treatment Plan --Benefit for each visit</p> <p>--Number of visits covered (must be received within 8 weeks of last Medicare Approved visits)</p> <p>--Calendar year maximum</p>	<p>100%</p> <p>\$[0]</p> <p>80%</p> <p>\$[0]</p> <p>\$[0]</p> <p>\$[0]</p>	<p>\$[0]</p> <p>\$[0]</p> <p>20%</p> <p>Actual Charges to \$[40] a visit</p> <p>Up to the number of Medicare Approved visits, not to exceed 7 each week</p> <p>\$[1,600]</p>	<p>\$[0]</p> <p>\$[100] (Part B Deductible)</p> <p>\$[0]</p> <p>Balance</p>

OTHER BENEFITS--NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>FOREIGN TRAVEL-- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside</p>			

the USA			
First \$250 each calendar year	[\$0]	[\$0]	[\$250]
Remainder of Charges	[\$0]	80% to a lifetime maximum of \$[50,000]	20% of amounts over the \$[50,000] lifetime maximum

OUTLINE OF COVERAGE
TABLE 7. PLAN E
MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive services 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 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve dates are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[912] (Part A Deductible) \$[228] a day \$[456] a day 100% of Medicare Eligible Expenses \$[0]	\$[0] \$[0] \$[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 21st thru 100th days 101st day and after	All approved amounts All but \$[114] a day \$[0]	\$[0] \$[0] \$[0]	\$[0] Up to \$ [114] a day All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[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 co-insurance for outpatient drugs and inpatient respite care	\$[0]	Balance
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****NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

**PLAN E
MEDICARE (PART B)--MEDICAL SERVICES--PER CALENDAR YEAR**

*Once you have been billed \$[110] 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 OUR 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% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

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]

(continued)

**Plan E
(continued)**

OTHER BENEFITS--NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>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 Remainder of Charges</p>	<p>\$[0] \$[0]</p>	<p>\$[0] 80% to a lifetime maximum of \$[50,000]</p>	<p>\$[250] 20% and amounts over the \$[50,000] lifetime maximum</p>
<p>*PREVENTIVE MEDICAL CARE BENEFIT --NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$[120] each calendar year Additional charges</p>	<p>\$[0] \$[0]</p>	<p>\$[120] \$[0]</p>	<p>\$[0] All costs</p>

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

OUTLINE OF COVERAGE
TABLE 8. 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 services 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 one has paid a calendar year [\$1730] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$1730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the 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 \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve dates are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[912] (Part A Deductible) \$[228] a day \$ [456] a day 100% of Medicare Eligible Expenses \$[0]	\$[0] \$[0] \$[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 21st thru 100th days 101st day and after	All approved amounts All but \$[114]a day \$[0]	\$[0] Up to [114]a day \$[0]	\$[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 co-insurance for outpatient drugs and inpatient respite care	\$[0]	Balance

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

**PLAN F or HIGH DEDUCTIBLE 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 one has paid a calendar year [\$1730] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$1730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the 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 \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES -- IN OUR 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* Remainder of Medicare Approved Amounts	\$[0] 80% (Generally)	\$[100] (Part B Deductible) 20% (Generally)	\$[0] \$[0]
Part B Excess Charges (Above Medicare Approved Amounts)	\$[0]	100%	\$[0]
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$[0] \$[0] 80%	All costs \$[100] (Part B Deductible) 20%	\$[0] \$[0] \$[0]
CLINICAL LABORATORY SERVICES-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
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 of \$[50,000]	20% and amounts over the \$[50,000] life-time maximum

OUTLINE OF COVERAGE

TABLE 9. PLAN G

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

*A benefit period begins on the first day you receive services 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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th days</p> <p>91st day and after: --While using 60 lifetime reserve days</p> <p>--Once lifetime reserve dates are used --Additional 365 days</p> <p>--Beyond the Additional 365 days</p>	<p>All but \$[912]</p> <p>All but \$[228] a day</p> <p>All but \$[456] a day</p> <p>\$[0]</p> <p>\$[0]</p>	<p>\$[912] (Part A Deductible)</p> <p>\$[228] a day</p> <p>\$ [456] a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$[0]</p>	<p>\$[0]</p> <p>\$[0]</p> <p>\$[0]</p> <p>\$[0]**</p> <p>All costs</p>
<p>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</p> <p>First 20 days</p> <p>21st thru 100th days</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$[114]a day</p> <p>\$[0]</p>	<p>\$[0]</p> <p>Up to [114]a day</p> <p>\$[0]</p>	<p>\$[0]</p> <p>\$[0]</p> <p>All costs</p>
<p>BLOOD First 3 pints</p> <p>Additional amounts</p>	<p>\$[0]</p> <p>100%</p>	<p>3 pints</p> <p>\$[0]</p>	<p>\$[0]</p> <p>\$[0]</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are</p>	<p>All but very limited co-</p>	<p>\$[0]</p>	<p>Balance</p>

terminally ill and you elect to receive these services	insurance for outpatient drugs and inpatient respite care		
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****NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

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 OUR 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% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

Plan G
(continued)
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 Home Care Treatment Plan			
--Benefit for each visit	\$[0]	Actual charges up 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]	

OTHER BENEFITS--NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 of \$[50,000]	20% and amounts over the \$[50,000] lifetime maximum

OUTLINE OF COVERAGE

TABLE 10. PLAN H

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

*A benefit period begins on the first day you receive services 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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th days</p> <p>91st day and after: --While using 60 lifetime reserve days</p> <p>--Once lifetime reserve dates are used --Additional 365 days</p> <p>--Beyond the Additional 365 days</p>	<p>All but \$[912]</p> <p>All but \$[228] a day</p> <p>All but \$[456] a day</p> <p>\$[0]</p> <p>\$[0]</p>	<p>\$[912] (Part A Deductible)</p> <p>\$[228] a day</p> <p>\$ [456] a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$[0]</p>	<p>\$[0]</p> <p>\$[0]</p> <p>\$[0]</p> <p>\$[0]**</p> <p>All costs</p>
<p>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</p> <p>First 20 days</p> <p>21st thru 100th days</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$[114]a day</p> <p>\$[0]</p>	<p>\$[0]</p> <p>Up to \$[114]a day</p> <p>\$[0]</p>	<p>\$[0]</p> <p>\$[0]</p> <p>All costs</p>
<p>BLOOD First 3 pints</p> <p>Additional amounts</p>	<p>\$[0]</p> <p>100%</p>	<p>3 pints</p> <p>\$[0]</p>	<p>\$[0]</p> <p>\$[0]</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are</p>	<p>All but very limited co-</p>	<p>\$[0]</p>	<p>Balance</p>

terminally ill and you elect to receive these services	insurance for outpatient drugs and inpatient respite care		
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****NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

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 OUR 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% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			

MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$[0]	\$[0]
--Durable medical equipment First \$110] of Medicare Approved Amounts*	\$[0]	\$[0]	\$[110] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$[0]

(continued)

Plan H
(continued)

OTHER BENEFITS--NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 Remainder of Charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum of \$[50,000]	\$[250] 20% and amounts over the \$[50,000] lifetime maximum

OUTLINE OF COVERAGE

TABLE 11. PLAN I

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

*A benefit period begins on the first day you receive services 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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th days</p> <p>91st day and after: --While using 60 lifetime reserve days</p> <p>--Once lifetime reserve dates are used --Additional 365 days</p> <p>--Beyond the Additional 365 days</p>	<p>All but \$[912]</p> <p>All but \$[228] a day</p> <p>All but \$[456] a day</p> <p>\$[0]</p> <p>\$[0]</p>	<p>\$[912] (Part A Deductible)</p> <p>\$[228] a day</p> <p>\$ [456] a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$[0]</p>	<p>\$[0]</p> <p>\$[0]</p> <p>\$[0]</p> <p>\$[0]**</p> <p>All costs</p>
<p>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</p> <p>First 20 days</p> <p>21st thru 100th days</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$[114]a day</p> <p>\$[0]</p>	<p>\$[0]</p> <p>Up to \$[114]a day</p> <p>\$[0]</p>	<p>\$[0]</p> <p>\$[0]</p> <p>All costs</p>
<p>BLOOD First 3 pints</p> <p>Additional amounts</p>	<p>\$[0]</p> <p>100%</p>	<p>3 pints</p> <p>\$[0]</p>	<p>\$[0]</p> <p>\$[0]</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are</p>	<p>All but very limited co-</p>	<p>\$[0]</p>	<p>Balance</p>

terminally ill and you elect to receive these services	insurance for outpatient drugs and inpatient respite care		
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****NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

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 OUR 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% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

Plan I
(continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts</p> <p>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 Home Care Treatment Plan --Benefit for each visit</p> <p>--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)</p> <p>--Calendar year maximum</p>	<p>100%</p> <p>\$[0]</p> <p>80%</p> <p>\$[0]</p> <p>\$[0]</p> <p>\$[0]</p>	<p>\$[0]</p> <p>\$[0]</p> <p>20%</p> <p>Actual Charges to \$[40] a visit</p> <p>Up to the number of Medicare Approved visits, not to exceed 7 each week</p> <p>\$[1,600]</p>	<p>\$[0]</p> <p>\$[100] (Part B Deductible)</p> <p>\$[0]</p> <p>Balance</p>

(continued)

Plan I
(continued)

OTHER BENEFITS--NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 Remainder of Charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum of \$[50,000]	\$[250] 20% and amounts over the \$[50,000] lifetime maximum

OUTLINE OF COVERAGE
TABLE 12. 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 services 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 one has paid a calendar year [\$1730] deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are [\$1730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate outpatient prescription drug deductible or the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve dates are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[912] (Part A Deductible) \$[228] a day \$ [456] a day 100% of Medicare Eligible Expenses \$[0]	\$[0] \$[0] \$[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 21st thru 100th days 101st day and after	All approved amounts All but \$[114]a day \$[0]	\$[0] Up to \$[114]a day \$[0]	\$[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 co-insurance for outpatient drugs and inpatient respite care	\$0	Balance

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

PLAN J or HIGH DEDUCTIBLE 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 one has paid a calendar year \$[1730] deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are \$[1730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES -- IN OUR 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* Remainder of Medicare Approved Amounts	\$[0] 80% (Generally)	\$[100] (Part B Deductible) 20% (Generally)	\$[0] \$[0]
Part B Excess Charges (Above Medicare Approved Amounts)	\$[0]	100%	\$[0]
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$[0] \$[0] 80%	All costs \$[100] (Part B Deductible) 20%	\$[0] \$[0] \$[0]
CLINICAL LABORATORY SERVICES-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

Plan J or HIGH DEDUCTIBLE PLAN J

(continued)

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
<p>HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts</p> <p>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 Home Care Treatment Plan --Benefit for each visit --Number of visits covered (must be received within 8 weeks of last Medicare Approved visit) --Calendar year maximum</p>	<p align="center">100%</p> <p align="center">80%</p> <p align="center">\$[0]</p> <p align="center">\$[0]</p> <p align="center">\$[0]</p> <p align="center">\$[0]</p> <p align="center">\$[0]</p>	<p align="center">\$[0]</p> <p align="center">\$[100] (Part B Deductible)</p> <p align="center">20%</p> <p align="center">Actual Charges to \$[40] a visit</p> <p align="center">Up to the number of Medicare Approved visits, not to exceed 7 each week</p> <p align="center">\$[1,600]</p>	<p align="center">\$[0]</p> <p align="center">\$[0]</p> <p align="center">\$[0]</p> <p align="center">Balance</p>

(continued)

Plan J or HIGH DEDUCTIBLE PLAN J
(continued)

PARTS A & B (continued)

OTHER BENEFITS--NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
<p>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</p> <p>Remainder of Charges</p>	<p>\$[0]</p> <p>\$[0]</p>	<p>\$[0]</p> <p>80% to a lifetime maximum of \$[50,000]</p>	<p>\$[250]</p> <p>20% and amounts over the \$[50,000] lifetime maximum</p>
<p>***PREVENTIVE MEDICAL CARE BENEFIT-- NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$[120] each calendar year</p> <p>Additional charges</p>	<p>\$[0]</p> <p>\$[0]</p>	<p>\$[120]</p> <p>\$[0]</p>	<p>\$[0]</p> <p>All Costs</p>

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

**OUTLINE OF COVERAGE
TABLE 13. PLAN K**

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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 \$[912]	\$[456](50% of Part A deductible)	\$[456](50% of Part A deductible)♦
61 st thru 90th day	All but \$[228] a day	\$[228] a day	\$[0]
91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used:	All but \$[456] a day	\$[456] a day	\$[0]
—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]
21 st thru 100th day	All but \$[100] a day	Up to \$[57] a day	Up to \$[57] a day ♦
101st day and after	\$[0]	\$[0]	All costs
BLOOD			
First 3 pints	\$[0]	50%	50%♦
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	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments♦
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(continued)

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

PLAN K

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**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$[0] Generally 75% or more of Medicare approved amounts Generally 80%	\$[0] Remainder of Medicare approved amounts Generally 10%	\$[100] (Part B deductible)**** ♦ All costs above Medicare approved amounts Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$[0]	\$[0]	All costs (and they do not count toward annual out-of-pocket limit of [\$4000])*
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$[0] \$[0] Generally 80%	50% \$[0] Generally 10%	50%♦ \$[100] (Part B deductible)**** ♦ Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[4000] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN K
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
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%	10%	10%♦

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

**OUTLINE OF COVERAGE
TABLE 14. PLAN L**

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[2000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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 \$[912]	\$[684] (75% of Part A deductible)	\$[228] (25% of Part A deductible)♦
61st thru 90th day	All but \$[228] a day	\$[228] a day	\$[0]
91st day and after: —While using 60 lifetime reserve days	All but \$[456] a day	\$[456] 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

<p>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 21st thru 100th day 101st day and after</p>	<p>All approved amounts All but \$[100] a day \$[0]</p>	<p>\$[0] Up to \$[85.50] a day \$[0]</p>	<p>\$[0] Up to \$[28.50] a day♦ All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$[0] 100%</p>	<p>75% \$[0]</p>	<p>25%♦ \$[0]</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care</p>	<p>75% of coinsurance or copayments</p>	<p>25% of coinsurance or copayments ♦</p>

(continued)

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

PLAN L

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**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$[0] Generally 75% or more of Medicare approved amounts Generally 80%	\$[0] Remainder of Medicare approved amounts Generally 15%	\$[100] (Part B deductible)**** ♦ All costs above Medicare approved amounts Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$[0]	\$[0]	All costs (and they do not count toward annual out-of-pocket limit of [\$2000])*
BLOOD First 3 pints Next \$[110] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$[0] \$[0] Generally 80%	75% \$[0] Generally 15%	25%♦ \$[100] (Part B deductible)♦ Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2000] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN L

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
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%	15%	5% ♦

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

**APPENDIX S. OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
OUTLINE OF COVERAGE - COVER PAGE [REVOKED]**

[COMPANY NAME]

Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

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

Plans E, J, I and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]

Basic Benefits:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved days after Medicare approved expenses) or copayments for hospitals outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER			
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess		Part B				

				(100%)	Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit \$[4140]; paid at 100% after limit reached	Out-of-pocket limit \$[2070]; paid at 100% after limit reached		

- **Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$1860] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

**OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
REQUIRED ITEMS**

PREMIUM INFORMATION [Boldface Type]

We [insert issuer'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 [Boldface Type]

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. [This paragraph shall not appear after June 1, 2011.]

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

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 [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer'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 [Boldface Type]

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 [Boldface Type]

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

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company'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 "Medicare and You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

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 prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to 365:10-5-128(d).]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Commissioner.]

OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
PLAN A
MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive services 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 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[0] \$[228] a day \$[456] a day 100% of Medicare Eligible Expenses \$[0]	\$[912] (Part A Deductible) \$[0] \$[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 21st thru 100th days 101st day and after	All approved amounts All but \$[114] a day \$[0]	\$[0] \$[0] \$[0]	\$[0] Up to \$ [114] a day All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]

<p>HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness</p>	<p>All but very limited copayment/co- insurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>[\$0]</p>
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****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN A
MEDICARE (PART B)--MEDICAL SERVICES--PER CALENDAR YEAR**

*Once you have been billed \$[100] of Medicare- 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 OUR 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% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

PARTS A & B

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$[0] 80%	\$[0] \$[0] 20%	\$[0] \$[100] (Part B Deductible) \$[0]

**OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
PLAN B
MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive services 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 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[912] (Part A Deductible) \$[228] a day \$[456] a day 100% of Medicare Eligible Expenses \$[0]	\$[0] \$[0] \$[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 21st thru 100th days 101st day and after	All approved amounts All but \$[100] a day \$[0]	\$[0] \$[0] \$[0]	\$[0] Up to \$ [100] a day All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE			

You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/co- insurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\${0}
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****NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

**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 OUR 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% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			

MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$[0]	\$[0]
--Durable medical equipment First \$[110] of Medicare Approved Amounts*	\$[0]	\$[0]	\$[110] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$[0]

OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
PLAN C
MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive services 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 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve dates are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[912] (Part A Deductible) \$[228] a day \$[456] a day 100% of Medicare Eligible Expenses \$[0]	\$[0] \$[0] \$[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 21st thru 100th days 101st day and after	All approved amounts All but \$[114] a day \$[0]	\$[0] \$[0] \$[0]	\$[0] Up to \$ [114] a day All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE			

You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/co- insurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\${0}
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****NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

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 OUR 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% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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]

(continued)

Plan C
(continued)

OTHER BENEFITS--NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 Remainder of Charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum of \$[50,000]	\$[250] 20% of amounts over the \$[50,000] lifetime maximum

**OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
PLAN D
MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive services 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 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve dates are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[912] (Part A Deductible) \$[228] a day \$[456] a day 100% of Medicare Eligible Expenses \$[0]	\$[0] \$[0] \$[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 21st thru 100th days 101st day and after	All approved amounts All but \$[114] a day \$[0]	\$[0] Up to \$[114] a day \$[0]	\$[0] \$ [0] All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE			

You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/co- insurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\${0}
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****NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

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 OUR 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% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

**Plan D
(continued)
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 of \$[50,000]	20% of amounts over the \$[50,000] lifetime maximum

OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
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 services 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 one has paid a calendar year [\$1730] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$1730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the 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 \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve dates are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[912] (Part A Deductible) \$[228] a day \$ [456] a day 100% of Medicare Eligible Expenses \$[0]	\$[0] \$[0] \$[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 21st thru 100th days 101st day and after	All approved amounts All but \$[114]a day \$[0]	\$[0] Up to [114]a day \$[0]	\$[0] \$[0] All costs
BLOOD First 3 pints	\$[0]	3 pints	\$[0]

Additional amounts	100%	\$[0]	\$[0]
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/co- insurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$[0]

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

**PLAN F or HIGH DEDUCTIBLE 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 one has paid a calendar year \$[1730] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[1730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the 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 \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES -- IN OUR 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* Remainder of Medicare Approved Amounts	\$[0] 80% (Generally)	\$[100] (Part B Deductible) 20% (Generally)	\$[0] \$[0]
Part B Excess Charges (Above Medicare Approved Amounts)	\$[0]	100%	\$[0]
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$[0] \$[0] 80%	All costs \$[100] (Part B Deductible) 20%	\$[0] \$[0] \$[0]
CLINICAL LABORATORY SERVICES-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
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 of \$[50,000]	20% and amounts over the \$[50,000] life-time maximum

**OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
PLAN G**

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

*A benefit period begins on the first day you receive services 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 \$[912]	\$[912] (Part A Deductible)	\$[0]
61st thru 90th days	All but \$[228] a day	\$[228] a day	\$[0]
91st day and after: --While using 60 lifetime reserve days	All but \$[456] a day	\$ [456] a day	\$[0]
--Once lifetime reserve dates 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 days	All but \$[114]a day	Up to [114]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 You must meet Medicare's requirements, including a	All but very limited	Medicare	\$[0]

doctor's certification of terminal illness	copayment/co- insurance for outpatient drugs and inpatient respite care	copayment/ coinsurance	
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****NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

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 OUR 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% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

Plan G
(continued)
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 Home Care Treatment Plan			
--Benefit for each visit	\$[0]	Actual charges up 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]	

OTHER BENEFITS--NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 of \$[50,000]	20% and amounts over the \$[50,000] lifetime maximum

**OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
PLAN K**

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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 \$[912]	\$[456](50% of Part A deductible)	\$[456](50% of Part A deductible)♦
61 st thru 90th day	All but \$[228] a day	\$[228] a day	\$[0]
91st day and after: —While using 60 lifetime reserve days	All but \$[456] a day	\$[456] 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]
21 st thru 100th day	All but \$[100] a day	Up to \$[57] a day	Up to \$[57] a day ♦
101st day and after	\$[0]	\$[0]	All costs
BLOOD First 3 pints	\$[0]	50%	50%♦
Additional amounts	100%	\$[0]	\$[0]

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayments/coinsurance	50% of Medicare copayments/coinsurance♦
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(continued)

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

PLAN K

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**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$[0] Generally 75% or more of Medicare approved amounts Generally 80%	\$[0] Remainder of Medicare approved amounts Generally 10%	\$[100] (Part B deductible)**** ♦ All costs above Medicare approved amounts Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$[0]	\$[0]	All costs (and they do not count toward annual out-of-pocket limit of [\$4000])*
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$[0] \$[0] Generally 80%	50% \$[0] Generally 10%	50%♦ \$[100] (Part B deductible)**** ♦ Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[4000] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN K
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
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%	10%	10%♦

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

**OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
PLAN L**

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[2000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[684] (75% of Part A deductible) \$[228] a day \$[456] a day 100% of Medicare eligible expenses \$[0]	\$[228] (25% of Part A deductible)♦ \$[0] \$[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 21 st thru 100th day 101st day and after	All approved amounts All but \$[100] a day \$[0]	\$[0] Up to \$[85.50] a day \$[0]	\$[0] Up to \$[28.50] a day♦ All costs

BLOOD First 3 pints Additional amounts	[\$0] 100%	75% [\$0]	25%♦ [\$0]
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayments/coinsurance	50% of Medicare copayments/coinsurance♦

(continued)

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

PLAN L

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**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$[0] Generally 75% or more of Medicare approved amounts Generally 80%	\$[0] Remainder of Medicare approved amounts Generally 15%	\$[100] (Part B deductible)**** ♦ All costs above Medicare approved amounts Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$[0]	\$[0]	All costs (and they do not count toward annual out-of-pocket limit of [\$2000])*
BLOOD First 3 pints Next \$[110] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$[0] \$[0] Generally 80%	75% \$[0] Generally 15%	25%♦ \$[100] (Part B deductible)♦ Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2000] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN L

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
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%	15%	5% ♦

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

**OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
PLAN M**

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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days</p> <p>—Beyond the additional 365 days</p>	<p>All but \$[1068]</p> <p>All but \$[267] a day</p> <p>All but \$[534] a day</p> <p>\$[0]</p> <p>\$[0]</p>	<p>\$[534](50% of Part A deductible) \$[267] a day</p> <p>\$[534] a day</p> <p>100% of Medicare eligible expenses \$[0]</p>	<p>\$[534](50% of Part A deductible) \$[0]</p> <p>\$[0]</p> <p>\$[0]**</p> <p>All costs</p>
<p>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</p> <p>First 20 days 21st thru 100th day 101st day and after</p>	<p>All approved amounts All but \$[133.50] a day \$[0]</p>	<p>\$[0] Up to \$[133.50] a day \$[0]</p>	<p>\$[0] \$0 All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$[0] 100%</p>	<p>3 pints \$[0]</p>	<p>\$[0] \$[0]</p>
<p>HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness</p>	<p>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$[0]</p>

(continued)

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

PLAN M

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

* Once you have been billed \$[135] 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 physi- cian’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$[135] of Medicare Approved Amounts*	\$[0]	\$[0]	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$[0]
Part B Excess Charges (Above Medicare Approved Amounts)	\$[0]	\$[0]	All costs
BLOOD First 3 pints	\$[0]	All costs	\$[0]
Next \$[135] of Medicare Approved Amounts*	\$[0]	\$[0]	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$[0]
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	100%	\$[0]
—Durable medical equipment First \$[135] of Medicare Approved Amounts*	\$[0]	\$[0]	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$[0]

(continued)

PLAN M

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 maxi-mum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
PLAN N**

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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days</p>	<p>All but \$[1068] All but \$[267] a day</p> <p>All but \$[534] a day</p> <p>\$[0]</p> <p>\$[0]</p>	<p>\$[1068](Part A deductible) \$[267] a day</p> <p>\$[534] a day</p> <p>100% of Medicare eligible expenses</p> <p>\$[0]</p>	<p>\$[0] \$0</p> <p>\$[0]</p> <p>\$[0]**</p> <p>All costs</p>
<p>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</p> <p>First 20 days 21st thru 100th day 101st day and after</p>	<p>All approved amounts All but \$[133.50] a day \$[0]</p>	<p>\$[0] Up to \$[133.50] a day \$[0]</p>	<p>\$[0] \$[0] All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$[0] 100%</p>	<p>3 pints \$[0]</p>	<p>\$[0] \$[0]</p>
<p>HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness</p>	<p>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/coinsurance</p>	<p>\$[0]</p>

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

PLAN N

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

* Once you have been billed \$[135] 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 \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$[0] Generally 80%	\$[0] Balance, other than up to \$[20] per office visit and up to \$[50] per emergency room visit. The copayment of up to \$[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$[135] (Part B deductible) up to \$[20] per office visit and up to \$[50] per emergency room visit. The copayment of up to \$[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	\$[0]	\$[0]	All costs
BLOOD First 3 pints Next \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$[0] 80%	\$[0] \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]
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PLAN N

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 maxi-mum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum