

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

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Part 13. Medicare Supplement Insurance Minimum Standards

365:10-5-123. Definitions [AMENDED]

365:10-5-127. Benefit standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates issued or delivered on or after July 1, 1992 and Prior to June 1, 2010 [AMENDED]

365:10-5- 127.1. Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After June 1, 2010 [NEW]

365:10-5-128. Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After [insert effective date adopted by state] and Prior to June 1, 2010 [AMENDED]

365:10-5-128.1. Medicare Select Policies and Certificates [AMENDED AND RENUMBERED TO 365:10-5-128.3]

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 [NEW]

365:10-5-128.3. Medicare Select Policies and Certificates [NEW]

365:10-5-129. Open enrollment [AMENDED]

365:10-5-129.1. Guaranteed Issue for Eligible Persons [AMENDED]

365:10-5-131. Loss ratio standards and refund or credit of premium [AMENDED]

365:10-5-134. Required disclosure provisions

365:10-5-143. Prohibition Against Use of Genetic Information and Requests for Genetic Testing [NEW]

Appendix S. Outline of Coverage [REVOKED AND REENACTED]

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Insurance Commissioner, 36 O.S. §§ 307.1, 3610, 3611 and 3611.1

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ANALYSIS:

The proposed amendments to Part 13 of Subchapter 5, Medicare Supplement Insurance Minimum Standards, 365:10-5-123 through 143 and Appendix S, update the regulation to the most recent National Association of Insurance Commissioners' model regulation and implement federal mandates.

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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 1, 2009

PART 13. MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

365:10-5-123. Definitions

The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:

"Applicant" means:

(A) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

(B) In the case of a group Medicare supplement policy, the proposed certificateholder.

"Bankruptcy" means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

"Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

"Certificate Form" means the form on which the certificate is delivered or issued for delivery by the issuer.

"Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

"Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(A) A group health plan;

(B) Health insurance coverage;

(C) Part A or Part B of title XVIII of the Social Security Act (Medicare);

- (D) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;
- (E) Chapter 55 of Title 10 United States Code (CHAMPUS);
- (F) A medical care program of the Indian Health Service or of a tribal organization; ~~A states health benefits risk pool;~~
- (G) A state health benefits risk pool;
- ~~(GH) A state health benefits program;~~
- ~~(HI) A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);~~
- ~~(IJ) A public health plan as defined in federal regulation; and~~
- ~~(JK) A health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).~~

"Creditable coverage" shall not include one or more, or any combination of the following:

- (A) Coverage only for accident or disability income insurance, or any combination thereof;
- (B) Coverage issued as a supplement to liability insurance;
- (C) Liability insurance, including general liability insurance and automobile liability insurance;
- (D) Workers' compensation or similar insurance;
- (E) Automobile medical payment insurance;
- (F) Credit-only insurance;
- (G) Coverage for on-site medical clinics; and
- (H) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

"Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

- (A) Limited scope dental or vision benefits;
- (B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
- (C) Such other similar, limited benefits as are specified in federal regulations.

"Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

- (A) Coverage only for a specified disease or illness; and
- (B) Hospital indemnity or other fixed indemnity insurance.

"Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

- (A) Medicare supplemental health insurance as defined under Section 1822(g)(1) of the Social Security Act;
- (B) Coverage supplemental to the coverage provided under Chapter 55 of the Title 10, United States Code; and
- (C) Similar supplemental coverage provided to coverage under a group health plan.

"Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

"Insolvency" means an issuer is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

"**Issuer**" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

"**Medicare**" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

"**Medicare Advantage**" means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes:

- (A) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;
- (B) Medicare medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and
- (C) Medicare Advantage private fee-for-service plans.

"**Medicare Supplement Policy**" means a group or individual policy of accident and health insurance or a subscriber contract of a non-profit hospital service and medical indemnity corporation or health maintenance organization, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. "Medicare Supplement Policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under §1833(a)(1)(A) of the Social Security Act.

"**Pre-Standardized Medicare supplement benefit plan,**" "**Pre-Standardized benefit plan**" or "**Pre-Standardized plan**" means a group or individual policy of Medicare supplement insurance issued prior to July 1, 1992.

"**1990 Standardized Medicare supplement benefit plan,**" "**1990 Standardized benefit plan**" or "**1990 plan**" means a group or individual policy of Medicare supplement insurance issued on or after July 1, 1992 and prior to June 1, 2010 and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

"**2010 Standardized Medicare supplement benefit plan,**" "**2010 Standardized benefit plan**" or "**2010 plan**" means a group or individual policy of Medicare supplement insurance issued on or after June 1, 2010.

"**Policy Form**" means the form on which the policy is delivered or issued for delivery by the issuer.

"**Secretary**" means the Secretary of the United States Department of Health and Human Services.

365:10-5-127. Benefit standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates issued or delivered on or after July 1, 1992 and Prior to June 1, 2010

(a) **Benefit standards.** The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 1, 1992 and

prior to 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 standards.

(b) **General standards.** The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Part.

(1) **Preexisting conditions.** A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(2) **Sickness and accidents.** A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

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

(4) **Termination of coverage of a spouse.** No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) **Guaranteed renewable.** Each Medicare supplement policy shall be guaranteed renewable and

(A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(B) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(C) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under (b)(5)(E) of this section, the issuer shall offer certificateholders an individual Medicare supplement policy which at the option of the certificateholder:

- (i) provides for continuation of the benefits contained in the group policy, or
- (ii) provides for such benefits as otherwise meets the requirements of this subsection.

(D) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

- (i) offer the certificateholder the conversion opportunity described in (b)(5)(C) of this section, or
- (ii) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(E) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its

date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(F) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

(6) **Continuous loss.** Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7) **Suspension.** ~~A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period, not to exceed twenty four (24) months, in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance.~~

(A) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period, not to exceed twenty-four (24) months, in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance.

(B) If such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstated effective as of the date of termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period.

~~(B)~~(C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.

~~(C)~~ (D) Reinstatement of such coverages:

- (i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;
- (ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of such suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and
- (iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(8) If an issuer makes a written offer to the Medicare Supplement policyholders or certificateholders of one or more of its plans, to exchange during a specified period from his or her 1990 Standardized plan as described in O.A.C. 365:10-5-127 to a 2010 Standardized plan as described in O.A.C. 365:10-5-127.1, the offer and subsequent exchange shall comply with the following requirements:

(A) An issuer need not provide justification to the Commissioner if the insured replaces a 1990 Standardized policy or certificate with an issue age rated 2010 Standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the commissioner according to the state's rate filing procedure.

(B) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(C) An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six (6) months to any added benefits contained in the new 2010 Standardized policy or certificate not contained in the exchanged policy.

(D) The new policy or certificate shall be offered to all policyholders or certificateholders within a given plan, except where the offer or issue would be in violation of state or federal law.

(c) **Standards for basic ("Core") benefits common to Benefit Plans A-J.** Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic "core" package, but not in lieu thereof.

- (1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

- (2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
 - (3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, 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 balances;
 - (4) Coverage under Medicare Parts A and B for 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;
 - (5) Coverage for the coinsurance amount (or in the case of hospital outpatient department services under a prospective payment system, the copayment amount) of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.
- (d) **Standards for additional benefits.** The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by O.A.C. 365:10-5-128.
- (1) Medicare Part A Deductible. Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.
 - (2) Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.
 - (3) Medicare Part B Deductible. Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.
 - (4) Eighty Percent (80%) of the Medicare Part B Excess Charges. Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
 - (5) One Hundred Percent (100%) of the Medicare Part B Excess Charges. Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
 - (6) Basic Outpatient Prescription Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars (\$1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.
 - (7) Extended Outpatient Prescription Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible to a maximum of three thousand dollars (\$3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.
 - (8) Medically Necessary Emergency Care in a Foreign Country. Coverage to the

extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) Preventive Medical Care Benefit. Coverage for the following preventive health services not covered by Medicare:

(A) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (B) of this paragraph and patient education to address preventive health care measures.

(B) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician. Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars (\$120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) At-Home Recovery Benefit. Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(A) For purposes of this benefit, the following definitions shall apply:

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

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

(iii) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

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

(B) Coverage requirements and limitations are as follows:

(i) At-home recovery services provided must be primarily services which assist in activities of daily living.

(ii) The insured's attending physician must certify that the specific type

and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to:

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

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars (\$40) per visit;

(III) One thousand six hundred dollars (\$1,600) per calendar year;

(IV) Seven (7) visits in any one week;

(V) Care furnished on a visiting basis in the insured's home;

(VI) Services provided by a care provider as defined in this section;

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

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

(C) Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and

(ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

(e) **Standards for Plans K and L**

(1) Standardized Medicare supplement benefit plan "K" shall consist of the following:

(A) 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) 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) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expense for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit an 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 (J);

(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 (J);

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

(G) 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 (J);

(H) Except for coverage provided in Subparagraph (I) below, 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 (J) below;

(I) 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) Coverage of One Hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance fo the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of Four Thousand dollars (\$4,000.00) in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(2) Standardized Medicare supplement benefit plan "L" shall consist of the following:

(A) The benefits described in Paragraphs (1) (A), (B), (C) and (I);

(B) The benefits described in Paragraphs (1) (D), (E), (F), (G) and (H), but substituting Seventy Five percent (75%) for Fifty percent (50%); and

(C) The benefit described in Paragraph (1) (J), but substituting Two Thousand dollars (\$2,000.00) for Four Thousand dollars (\$4,000.00).

365:10-5-127.1. Benefit standards for 2010 Standardized Medicare Supplement Benefit Plan policies or certificates issued for delivery on or after June 1, 2010

(a) Benefit Standards. 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 standards. No issuer may offer any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit 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) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

- (1) **Preexisting conditions.** A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.
- (2) **Sickness and accidents.** A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
- (3) **Benefits designed to cover cost sharing amounts under Medicare.** A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment factors. Premiums may be modified to correspond with such changes.
- (4) **Termination of coverage of a spouse.** No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.
- (5) **Guaranteed renewable.** Each Medicare supplement policy shall be guaranteed renewable.
- (A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.
- (B) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.
- (C) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under O.A.C. 365:10-5-127.1(b)(5)(E) of this regulation, the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):
- (i) Provides for continuation of the benefits contained in the group policy; or
- (ii) Provides for benefits that otherwise meet the requirements of this Subsection.
- (D) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall
- (i) Offer the certificateholder the conversion opportunity described in Section 8.1A(5)(c) of this regulation; or
- (ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.
- (E) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.
- (6) **Continuous loss.** Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was

in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7) **Suspension.**

(A) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

(B) If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.

(D) Reinstatement of coverages as described in Subparagraphs (B) and (C):

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

(iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(c) **Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M and N.** Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic “core” package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) 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;

(4) Coverage under Medicare Parts A and B for 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;

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

(6) Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

(d) **Standards for additional benefits.** The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by O.A.C. 365:10-5-128.2.

(1) Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

(3) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(4) Medicare Part B Deductible: Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

365:10-5-128. Standard Medicare Supplement Benefit Plans plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates issued for delivery on or after July 1, 1992, and prior to June 1, 2010

(a) 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(c).

(b) 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 Sections ~~365:10-5-128(g) and 365:10-5-128.1~~ 365:10-5-128.3 of this regulation.

(c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "L" 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(c) and (d) or O.A.C. Section 365:10-5-127(e) and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

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

(e) Make-up of benefit plans are as follows:

(1) Standardized Medicare supplement benefit plan "A" shall be limited to the Basic ("Core") Benefits Common to All Benefit Plans, as defined in 365:10-5-127(c).

(2) Standardized Medicare supplement benefit plan "B" shall include only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible as defined in 365:10-5-127(d)(1).

(3) Standardized Medicare supplement benefit plan "C" shall include only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in 365:10-5-127(d)(1), (2), (3) & (8) respectively.

(4) Standardized Medicare supplement benefit plan "D" shall include only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in an Foreign Country and the At-Home Recovery Benefit as defined in 365:10-5-127(d) (1), (2), (8) & (10) respectively.

(5) Standardized Medicare supplement benefit plan "E" shall include only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in 365:10-5-127(d) (1), (2), (8) & (9) respectively.

(6) Standardized Medicare supplement benefit plan "F" shall include only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the 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(d) (1), (2), (3), (5) & (8) respectively.

(7) Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined

in Section 365:10-5-127(c) of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, 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 Section 365:10-5-127(d)(1), (2), (3), (5) and (8) respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be \$1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary 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 \$10.

(8) Standardized Medicare supplement benefit plan "G" shall include only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Eighty Percent (80%) of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in 365:10-5-127(d) (1), (2), (4), (8) & (10) respectively.

(9) Standardized Medicare supplement benefit plan "H" shall consist of only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in 365:10-5-127(d) (1), (2), (6) & (8) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(10) Standardized Medicare supplement benefit plan "I" shall consist of only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in 365:10-5-127(d) (1), (2), (5), (6), (8) & (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(11) Standardized Medicare supplement benefit plan "J" shall consist of only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in 365:10-5-127(d) (1), (2), (3), (5), (7), (8), (9) & (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(12) Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in Section 365:10-5-127(c) of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign county, preventive medical care benefit and at-home recovery benefit as defined in Sections 365:10-5-127(d)(1), (2), (3), (5), (7),

(8), (9) and (10) respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be \$1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary 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 \$10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(ef) Make up of two Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA);

(1) Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in Section 365:10-5-127(e)(1).

(2) Standardized Medicare supplement benefit plan "L" shall consist of only those benefits described in Section 365:10-5-127(e)(2).

(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 benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefits.

365:10-5-128.1. Medicare Select Policies and Certificates [AMENDED AND RENUMBERED TO 365:10-5-128.3]

~~(a) — Application. This section shall apply to Medicare Select policies and certificates, as defined in this section. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.~~

~~(b) — Definitions. For the purposes of this section:~~

~~(1) — "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.~~

~~(2) — "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.~~

~~(3) — "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.~~

~~(4) — "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.~~

~~(5) — "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.~~

~~(6) — "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.~~

~~(7) — "Service area" means the geographic area approved by the Commissioner within which an issuer is authorized to offer a Medicare Select policy.~~

~~(c) — Authorization. The Commissioner may authorize an issuer to offer a Medicare Select~~

~~policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the Commissioner finds that the issuer has satisfied all of the requirements of this regulation.~~

~~(d) — Plan of operation approval. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the Commissioner.~~

~~(e) — Plan of operation requirements. A Medicare Select issuer shall file a proposed plan of operation with the Commissioner in a format prescribed by the Commissioner. The plan of operation shall contain at least the following information:~~

~~(1) — Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:~~

~~(A) — Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after hour care. The hours of operation and availability of after hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.~~

~~(B) — The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:~~

~~(i) To deliver adequately all services that are subject to a restricted network provision; or~~

~~(ii) To make appropriate referrals.~~

~~(C) — There are written agreements with network providers describing specific responsibilities.~~

~~(D) — Emergency care is available twenty four (24) hours per day and seven (7) days per week.~~

~~(E) — In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.~~

~~(2) — A statement or map providing a clear description of the service area.~~

~~(3) — A description of the grievance procedure to be utilized.~~

~~(4) — A description of the quality assurance program, including:~~

~~(A) — The formal organizational structure;~~

~~(B) — The written criteria for selection, retention and removal of network providers; and~~

~~(C) — The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.~~

~~(5) — A list and description, by specialty, of the network providers.~~

~~(6) — Copies of the written information proposed to be used by the issuer to comply with Subsection (i).~~

~~(7) — Any other information requested by the Commissioner.~~

~~(f) — Plan of operation amendments. A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the Commissioner prior to implementing the changes. Changes shall be considered approved by the~~

~~Commissioner after thirty (30) days unless specifically disapproved. An updated list of network providers shall be filed with the Commissioner at least quarterly.~~

~~(g) — Non network providers. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non network providers if:~~

~~(1) — The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and~~

~~(2) — It is not reasonable to obtain services through a network provider.~~

~~(h) — Unavailable services. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.~~

~~(i) — Full disclosure. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:~~

~~(1) — An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:~~

~~(A) — Other Medicare supplement policies or certificates offered by the issuer; and~~

~~(B) — Other Medicare Select policies or certificates.~~

~~(2) — A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.~~

~~(3) — A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out of network providers do not count toward the out of pocket annual limit contained in plans K and L.~~

~~(4) — A description of coverage for emergency and urgently needed care and other out of service area coverage.~~

~~(5) — A description of limitations on referrals to restricted network providers and to other providers.~~

~~(6) — A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.~~

~~(7) — A description of the Medicare Select issuer's quality assurance program and grievance procedure.~~

~~(j) — Proof of full disclosure. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection (i) of Section 365:10-5-128.1 and that the applicant understands the restrictions of the Medicare Select policy or certificate.~~

~~(k) — Grievance procedures. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement.~~

~~(1) — The grievance procedure shall be described in the policy and certificates and in the outline of coverage.~~

~~(2) — At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the~~

issuer.

~~(3) — Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision makers who have authority to fully investigate the issue and take corrective action.~~

~~(4) — If a grievance is found to be valid, corrective action shall be taken promptly.~~

~~(5) — All concerned parties shall be notified about the results of a grievance.~~

~~(6) — The issuer shall report no later than each March 31st to the Commissioner regarding its grievance procedure. The report shall be in a format prescribed by the Commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.~~

~~(l) — Opportunity to purchase Medicare supplement.~~

~~(1) — At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.~~

~~(2) — At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.~~

~~(3) — For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at home recovery services or coverage for Part B excess charges.~~

~~(m) — Coverage upon termination of program. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.~~

~~(1) — Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.~~

~~(2) — For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at home recovery services or coverage for Part B excess charges.~~

~~(n) — Cooperation with state and federal agencies. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select~~

Program.

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: 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.

365:10-5-128.3. Medicare Select Policies and Certificates [AMENDED AND RENUMBERED FROM 365:10-5-128.1]

(a) **Application.** This section shall apply to Medicare Select policies and certificates, as defined in this section. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(b) **Definitions.** For the purposes of this section:

(1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(3) "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(4) "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

(5) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

(6) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) "Service area" means the geographic area approved by the Commissioner within which an issuer is authorized to offer a Medicare Select policy.

(c) **Authorization.** The Commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the Commissioner finds that the issuer has satisfied all of

the requirements of this regulation.

(d) **Plan of operation approval.** A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the Commissioner.

(e) **Plan of operation requirements.** A Medicare Select issuer shall file a proposed plan of operation with the Commissioner in a format prescribed by the Commissioner. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(A) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(B) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) To deliver adequately all services that are subject to a restricted network provision; or

(ii) To make appropriate referrals.

(C) There are written agreements with network providers describing specific responsibilities.

(D) Emergency care is available twenty-four (24) hours per day and seven (7) days per week.

(E) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) A statement or map providing a clear description of the service area.

(3) A description of the grievance procedure to be utilized.

(4) A description of the quality assurance program, including:

(A) The formal organizational structure;

(B) The written criteria for selection, retention and removal of network providers; and

(C) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(5) A list and description, by specialty, of the network providers.

(6) Copies of the written information proposed to be used by the issuer to comply with Subsection (i).

(7) Any other information requested by the Commissioner.

(f) **Plan of operation amendments.** A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the Commissioner prior to implementing the changes. Changes shall be considered approved by the Commissioner after thirty (30) days unless specifically disapproved. An updated list of network providers shall be filed with the Commissioner at least quarterly.

(g) **Non-network providers.** A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

- (1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and
- (2) It is not reasonable to obtain services through a network provider.

(h) **Unavailable services.** A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

(i) **Full disclosure.** A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(A) Other Medicare supplement policies or certificates offered by the issuer; and

(B) Other Medicare Select policies or certificates.

(2) A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

(3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L.

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

(5) A description of limitations on referrals to restricted network providers and to other providers.

(6) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

(7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.

(j) **Proof of full disclosure.** Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection (i) of this Section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

(k) **Grievance procedures.** A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement.

(1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take

corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 31st to the Commissioner regarding its grievance procedure. The report shall be in a format prescribed by the Commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

(1) Opportunity to purchase Medicare supplement.

(1) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(2) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

(3) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

(m) Coverage upon termination of program. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

(n) Cooperation with state and federal agencies. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

365:10-5-129. Open enrollment

(a) ~~An~~ ~~no~~ issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this State, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subsection without regard to age.

(b) If an applicant qualifies under subsection (a) or subsection (d) of this Section and submits an application during the time period referenced in said subsection (a) or subsection (d)), and

(1) as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition; or

(2) as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

(c) Except as provided in Subsection (b) and Section 365:10-5-140, subsection (a) and subsection (d) of this Section shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

(d) At least one of the ten standardized Medicare supplement plans currently available from an issuer shall be made available to all applicants who qualify under this subsection by reason of disability. The issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this State because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such policy or certificate is submitted during the six (6) month period beginning with the first month in which an individual first enrolled for benefits under Medicare Part B.

(e) In the event Social Security backdates the Medicare enrollment date, the six-month enrollment period shall be calculated from the date the individual first receives notification of approval of Medicare coverage.

365:10-5-129.1. Guaranteed Issue for Eligible Persons

(a) **Guaranteed Issue.**

(1) Eligible persons are those individuals described in subsection (b) who apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in subsection (b), and who submit evidence of the date of termination, disenrollment or Medicare Part D enrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (c) that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims

experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(b) **Eligible Persons.** An eligible person is an individual described in any of the following paragraphs:

(1) **Employee welfare benefit plan.** The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all or substantially all supplemental health benefits to the individual.

(2) **Medicare Advantage.** The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(A) The ~~certification of the organization's organization or plan's plan certification [under this part]~~ has been terminated;

~~(B)~~ ~~or the~~ The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

~~(B)~~ The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

~~(D)~~ The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

~~(E)~~ The individual meets such other exceptional conditions as the Secretary may provide.

(3) **Organizations.**

(A) The individual is enrolled with:

(i) An eligible organization under a contract under Section 1876 (Medicare risk or cost);

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

- (iii) An organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or
 - (iv) An organization under a Medicare Select Policy; and
 - (B) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 365:10-5-129.1(b)(2).
- (4) **Medicare supplement.** The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:
 - (A) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or because of other involuntary termination of coverage or enrollment under the policy;
 - (B) The issuer of the policy substantially violated a material provision of the policy; or
 - (C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;
- (5) **Termination of enrollment and subsequent enrollment.** The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare risk or cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act or a Medicare Select Policy; and an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan), or a Medicare Select policy; and the subsequent enrollment under this subparagraph is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or
- (6) **Medicare Advantage disenrollment.**
 - (A) The individual, upon first becoming ~~both enrolled in~~ eligible for benefit under Medicare Part A of Medicare and at age 65 years of age or older, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan by not later than twelve (12) months after the effective date of enrollment.
 - (B) ~~The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Subsection 365:10-5-129.1(e)(4).~~
 - ~~(C)~~ An individual, under age 65, who first becomes eligible for Medicare Part B and enrolls in a Medicare Advantage plan under part C of Medicare, and disenrolls from the plan by not later than twelve (12) months after the effective date of enrollment.
- (7) **Part D Benefit Enrollment.** The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled

under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Subsection 365:10-5-129.1(e)(4).

(c) **Guaranteed issue time periods.**

(1) In the case of an individual described in Section 365:10-5-129.1(b)(1), the guaranteed issue period begins on the later of the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

(2) In the case of an individual described in Section 365:10-5-129.1(b)(2), (b)(3), (b)(5) or (b)(6) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;

(3) In the case of an individual described in Section 365:10-5-129.1(b)(4)(A), the guaranteed issue period begins on the earlier of the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated.

(4) In the case of an individual described in Section 365:10-5-129.1(b)(2), (b)(4)(B), (b)(4)(C), (b)(5) or (b)(6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;

(5) In the case of an individual described in Subsection 365:10-5-129.1(b)(6), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day (60) period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

(6) In the case of an individual described in Section 365:10-5-129.1(b) but not described in the preceding provisions of this Subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.

(d) **Extended Medigap access for interrupted trial periods.**

(1) In the case of an individual described in Section 365:10-5-129.1(b)(5) (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Section 365:10-5-129.1(b)(5)(A) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 365:10-5-129.1(b)(5);

(2) In the case of an individual described in Section 365:10-5-129.1(b)(6) (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Section 365:10-5-129.1(b)(6) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be

an initial enrollment described in Section 365:10-5-129.1(b)(6); and

(3) For purposes of Sections 365:10-5-129.1(b)(5) and (b)(6), no enrollment of an individual with an organization or provider described in Section 365:10-5-129.1(b)(5)(a), or with a plan or in a program described in Section 365:10-5-129.1(b)(6), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

(e) **Products to which eligible persons are entitled.** The Medicare supplement policy to which eligible persons are entitled under:

(1) **Section 365:10-5-129.1(b)(1), (2), (3) and (4).** Section 365:10-5-129.1(b)(1), (2), (3) and (4) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.

(2) **Section 365:10-5-129.1(b)(5).**

(A) Subject to subparagraph (B), Section 365:10-5-129.1(b)(5) is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Section 365:10-5-129.1(c)(1).

(B) After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this subparagraph is: The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or at the election of the policyholder, an A, B, C, F (including F with a high deductible, K or L policy that is offered by any issuer;

(3) **Section 365:10-5-129.1(b)(6)(A).** Section 365:10-5-129.1(b)(6)(A) shall include any Medicare supplement policy offered by any issuer.

(4) **Section 365:10-5-129.1(b)(6)(B).** Section 365:10-5-129.1(b)(6)(B) is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible, K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage .

(f) **Notification provisions.**

(1) At the time of an event described in Section 365:10-5-129.1(b) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Section 365:10-5-129.1(a). Such notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in Section 365:10-5-129.1(b) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Section 365:10-5-129.1(a). Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

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 in no less than twelve (12) point type. All plans ~~A-L~~ 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, in the order prescribed by Appendix S. The appropriate version of the outline of coverage as set out in Appendix S 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.

365:10-5-143. Prohibition Against Use of Genetic Information and Requests for Genetic Testing

(a) This Section applies to all policies with policy years beginning on or after May 21, 2009.

(b) An issuer of a Medicare supplement policy or certificate:

(1) Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; and

(2) Shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

(c) Nothing in Subsection (a) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from

(1) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

(2) Increasing the premium for any policy issued to an individual based on the

manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group).

(d) An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

(e) Subsection (c) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with Subsection (a).

(f) For purposes of carrying out Subsection (d), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

(g) Notwithstanding Subsection (c), an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

(1) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(2) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

(A) compliance with the request is voluntary; and

(B) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(3) No genetic information collected or acquired under this Subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

(4) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this Subsection, including a description of the activities conducted.

(5) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this Subsection.

(h) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

(i) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

(j) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of Subsection (h) if such request, requirement, or purchase is not in violation of Subsection (g).

(k) For the purposes of this Section only:

(1) "Issuer of a Medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer.

(2) “Family member” means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

(3) “Genetic information” means, with respect to any individual, information about such individual’s genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term “genetic information” does not include information about the sex or age of any individual.

(4) “Genetic services” means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

(5) “Genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term “genetic test” does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(6) “Underwriting purposes” means,

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(B) the computation of premium or contribution amounts under the policy;

(C) the application of any pre-existing condition exclusion under the policy; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

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

[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	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	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 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 (100%)		Part B Excess (80%)			Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	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

****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

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]

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

**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

****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	\$[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 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

**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 --Durable medical equipment First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts 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 visits) --Calendar year maximum	100% \$[0] 80% \$[0] \$[0] \$[0]	\$[0] \$[0] 20% Actual Charges to \$[40] a visit Up to the number of Medicare Approved visits, not to exceed 7 each week \$[1,600]	\$[0] \$[100] (Part B Deductible) \$[0] Balance Balance

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 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

****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</p> <p>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</p> <p>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 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 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

***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*	\$[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]	\$[100] (Part B Deductible)	\$[0]
Remainder of Medicare Approved Amounts	80%	20%	\$[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 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 terminally ill and you elect to receive these services</p>	<p>All but very limited co-insurance for outpatient drugs and inpatient respite care</p>	<p>\$[0]</p>	<p>Balance</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 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 terminally ill and you elect to receive these services</p>	<p>All but very limited co-insurance for outpatient drugs and inpatient respite care</p>	<p>\$[0]</p>	<p>Balance</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 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
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

****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
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 to \$[40] a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	[\$0]	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	[\$0]	[\$1,600]	

(continued)

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	\$[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 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 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

*****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>100% \$[0] 80%</p>	<p>\$[0] \$[100] (Part B Deductible) 20%</p>	<p>\$[0] \$[0] \$[0]</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>\$[0] \$[0] \$[0]</p>	<p>Actual Charges to \$[40] a visit Up to the number of Medicare Approved visits, not to exceed 7 each week \$[1,600]</p>	<p>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: —Additional 365 days	All but \$[456] a day \$[0]	\$[456] a day 100% of Medicare eligible expenses	\$[0] \$[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 Additional amounts	\$[0] 100%	50% \$[0]	50%♦ \$[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♦

(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 —Once lifetime reserve days are used: —Additional 365 days	All but \$[456] a day	\$[456] a day	\$[0]
—Beyond the additional 365 days	\$[0]	100% of Medicare eligible expenses	\$[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	All approved amounts All but \$[100] a day	\$[0] Up to \$[85.50] a day	\$[0] Up to \$[28.50] a day♦
101st day and after	\$[0]	\$[0]	All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	75% \$[0]	25%♦ \$[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	75% of coinsurance or copayments	25% of coinsurance or copayments ♦

(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****	\$[0]	\$[0]	\$[100] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	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****	\$[0] \$[0]	75% \$[0]	25%♦ \$[100] (Part B deductible)♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	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**

[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 (100%)		Part B 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]
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 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

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]

**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]

****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
<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>\$[0]</p> <p>\$[0]</p>	<p>\$[0]</p> <p>Up to \$ [114] a day</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 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>

****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	\$[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 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]

****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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies 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 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>

***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 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]

****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 —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 Additional amounts	\$[0] 100%	50% \$[0]	50%◆ \$[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 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****	\$[0]	\$[0]	\$[100] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	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****	\$[0] \$[0]	75% \$[0]	25%♦ \$[100] (Part B deductible)♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	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 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 All but \$[534] a day \$[0] \$[0]</p>	<p>\$[534](50% of Part A deductible) \$[267] a day \$[534] a day 100% of Medicare eligible expenses \$[0]</p>	<p>\$[534](50% of Part A deductible) \$[0] \$[0] \$[0]** 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 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 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*	\$[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%	\$[0]	\$[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

<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 maxi- mum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>
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**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 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 All but \$[534] a day \$[0] \$[0]</p>	<p>\$[1068](Part A deductible) \$[267] a day \$[534] a day 100% of Medicare eligible expenses \$[0]</p>	<p>\$[0] \$0 \$[0] \$[0]** 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 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

<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 maxi- mum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>
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