

INSURANCE DEPARTMENT OF THE STATE OF NEW YORK
REGULATION NO. 193
(11 NYCRR 58)
MINIMUM STANDARDS FOR FORM, CONTENT AND SALE OF
MEDICARE SUPPLEMENT AND MEDICARE SELECT INSURANCE, INCLUDING
STANDARDS OF FULL AND FAIR DISCLOSURE

I, James J. Wrynn, Superintendent of Insurance of the State of New York, pursuant to the authority granted by the federal Social Security Act (42 U.S.C. section 1395ss) and by Sections 201, 301, 3201, 3216, 3217, 3218, 3221, 3231, 3232, and 4235 and Article 43 of the Insurance Law, do hereby promulgate Part 58 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Regulation No. 193), to take effect upon publication in the State Register.

ALL NEW MATERIAL

Section 58.1 Rules relating to content of forms for Medicare supplement insurance

The following shall be applicable to Medicare supplement insurance as defined in Section 52.11 of this Title and shall be in addition to other requirements of this Part. Such rules shall apply to all Medicare supplement and Medicare select policies and certificates.

(a) Definitions.

(1) Subject to any provision dealing with preexisting conditions, incontestability or extension of benefits, the terms *accident*, *accidental injury*, or *accidental means* shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause." The definition may provide that injuries shall not include injuries for which benefits are provided under any state or federal workers' compensation, employers' liability or occupational disease law, or benefits to the extent provided for any loss, or portion thereof, for which mandatory automobile no-fault benefits are recovered or recoverable.

(2) *Applicant* means:

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

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

(3) *Benefit period* or *Medicare benefit period* shall not be defined more restrictively than as defined in the Medicare program.

(4) *Certificate* means any certificate delivered or issued for delivery in this state regardless of the situs of delivery of the group Medicare supplement policy.

(5) *Certificate form* means the form on which the certificate is delivered or issued for delivery by the issuer.

(6) The terms *convalescent nursing home*, *extended care facility*, or *skilled nursing facility* shall not be defined more restrictively than as defined in the Medicare program.

(7) (i) The term *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 and TRICARE health care programs for the uniformed military services);

(f) a medical care program of the Indian Health Service or of a tribal organization;

(g) a state health benefits risk pool;

(h) a health plan offered under chapter 89 of title 5, United States Code (Federal Employees Health Benefits Program);

(i) a public health plan;

(j) a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. section 2504[e]); and

(k) Medicare supplement insurance, Medicare select coverage or Medicare Advantage plan.

(ii) Except as specified in subparagraph (i) of this paragraph, creditable coverage shall not include any coverage in relation to its provision of "excepted benefits" as defined in section 2791(c) of the federal Public Health Service Act (42 U.S.C. section 300gg-91[c]) and meeting the requirements for exception as set forth in section 2721(c) or (d) of the federal Public Health Service Act (42 U.S.C. section 300gg-21[c] and [d] or section 2763[a] or [b] of the federal Public Health Service Act, 42 U.S.C. section 300gg-63[a] and [b]). However, this exemption shall not be applicable to any coverage providing hospital or surgical indemnity benefits with specific dollar amounts that exceed the amounts required to meet the definitions of basic hospital and basic medical insurance in sections 52.5 and 52.6 of this Title.

(iii) For purposes of subdivision (b)(3)(ii) of this section, credit for the time that a person was previously covered under part A or part B of title XVIII of the Social Security Act (Medicare) shall be required only if the applicant submits an application for Medicare supplement insurance prior to or

during the six-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.

(8) The term *health care expenses* shall mean expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. Expenses shall not include:

(i) home office and overhead costs;

(ii) advertising costs;

(iii) commissions and other acquisition costs;

(iv) taxes;

(v) capital costs;

(vi) administrative costs; and

(vii) claims processing costs.

(9) The term *hospital* may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

(10) The term *issuer* includes insurance companies, fraternal benefit societies, not-for-profit health service, hospital service or medical expense indemnity corporations, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement insurance policies or certificates.

(11) The term *Medicare* shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

(12) *Medicare Advantage plan* 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:

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

- (ii) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and
- (iii) Medicare Advantage private fee-for-service plans.
- (13) The term *Medicare eligible expenses* shall mean expenses of the kinds covered by Medicare parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
- (14) The term *physician* shall not be defined more restrictively than as defined in the Medicare program.
- (15) *Policy form* means the form on which the policy is delivered or issued for delivery by the issuer.
- (16) *Secretary* means the Secretary of the United States Department of Health and Human Services.
- (17) Subject to any provision dealing with preexisting conditions, incontestability or extension of benefits, the term *sickness* shall not be defined to be more restrictive than the following: illness or disease of an insured person. The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any state or federal workers' compensation, employers' liability or occupational disease law.
- (b) Policy practices and provisions.
- (1) (i) Every Medicare supplement insurance policy must be *guaranteed renewable*. Subject to a group policyholder's right to terminate coverage, the term *guaranteed renewable* as used in this section means that the insured has the right to continue the Medicare supplement insurance in force by the timely payment of premiums and the issuer has no unilateral right to make any change in any provision of the policy or certificate while the insurance is in force except to:
- (a) change benefits designed to cover cost-sharing amounts under Medicare to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors;
- (b) amend the policy to meet minimum standards for Medicare supplement insurance; or
- (c) revise premium rates on a class basis.
- (ii) If a group Medicare supplement insurance policy provides for termination of the policy by the group policyholder then the Medicare supplement certificate shall prominently display notification of such termination right on the first page.
- (2) 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 or certificate and shall include any reservation by the issuer of the right to change premiums.
- (3) (i) Notwithstanding section 52.16(c) of this Title, the only permissible preexisting condition limitations applicable to Medicare supplement insurance are ones which exclude coverage, for no more than six months after the effective date of coverage under the policy or certificate, for a condition for which medical advice was given or treatment was recommended by or received from a physician, within six months before the effective date of the coverage.

(ii) In applying a preexisting condition limitation to a covered person, an issuer shall credit the time the person was previously covered under creditable coverage, including Medicare supplement insurance, Medicare select coverage and Medicare Advantage plans, if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new coverage. For purposes of this paragraph, enrollment date means the first day of coverage of the individual under the policy or certificate or, if earlier, the first day of the waiting period that must pass with respect to an individual before such individual is eligible to be covered for benefits. Any period after the date the individual files a substantially complete application for coverage and before the first day of coverage is a waiting period.

(iii) For purposes of applying the credit of creditable coverage, an issuer shall reduce the period of any preexisting condition limitation by the aggregate of the period of creditable coverage without regard to the specific benefits covered during the period.

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

(4) Except for permitted preexisting condition limitations as described in paragraph (3) of this subdivision, no policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(5) No Medicare supplement insurance policy or certificate in force in this state shall contain benefits that duplicate benefits provided by Medicare.

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

(7) 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 co-payment percentage factors. Premiums may be changed to correspond with such changes, subject to approval by the superintendent.

(8) Medicare supplement insurance 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.

(9) An issuer shall provide, prior to its use, a copy of any advertisement for a Medicare supplement insurance policy or certificate intended for use in this state whether through written, radio or television medium to the superintendent for review. Such advertisement shall comply with all applicable regulations and laws of this state.

(10) 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 insurance, 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.

(11) 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 30 days of its delivery to the policyholder or certificateholder and to receive a full refund of any premium paid therefor including any policy fees or other charges.

(12) (i) Subject to subdivision (c) of this section, a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed at the option of the policyholder for current policyholders who do not enroll in part D.

(ii) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

(iii) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare part D unless:

(a) the policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a part D plan; and

(b) premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare part D enrollment, accounting for any claims paid, if applicable.

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

(c) Termination; conversion; continuation; suspension and reinstatement of coverage; extension of benefits.

(1) An issuer shall not cancel or nonrenew a Medicare supplement insurance policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(2) An issuer shall not cancel or nonrenew a Medicare supplement insurance policy or certificate on the ground of health status of the insured.

(3) No Medicare supplement insurance 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.

(4) If a group Medicare supplement insurance policy is replaced by another group Medicare supplement insurance 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.

(5) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in paragraph (4) of this subdivision, the issuer shall offer certificateholders an individual Medicare supplement insurance policy which (at the option of the certificateholder):

(i) provides for the same level of benefits contained in the group policy; or

(ii) provides for benefits that otherwise meet the requirements of this section.

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

(i) offer the certificateholder the conversion opportunities described in paragraph (5) of this subdivision; or

(ii) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(7) (i) 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 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 90 days after the date the individual becomes entitled to such assistance. Upon receipt of timely notice, the issuer shall return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

(ii) 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) as of the termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(iii) Each Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder or certificateholder if the policyholder or certificateholder is entitled to benefits under 42 U.S.C. section 426(b) and is covered under a group health plan (as defined in 42 U.S.C. section 1395y(b)(1)(A)(v)). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy or certificate shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder or certificateholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

(iv) Reinstitution of such coverages:

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

(b) 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

(c) 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) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy or certificate was in force, but the extension of benefits beyond the period during which the policy or certificate was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. If no specific benefit period is provided, an extended benefit period of at least 12 months must be included in the policy or certificate. A loss shall commence when a medical service, whether or not covered by the policy or certificate, is rendered for the condition causing total disability. Receipt of Medicare part D benefits will not be considered in determining a continuous loss.

(d) Applications for Medicare supplement insurance. In addition to the requirements set forth in section 52.51 of this Title, the following provisions shall apply to applications for Medicare supplement insurance:

(1) Applications may not contain any questions dealing with the health or health history of the applicant and no physical examination may be requested.

(2) Applications for Medicare supplement insurance shall include a conspicuous bold face notice advising the applicant that the sale of a Medicare supplement policy is prohibited where an individual has a Medicare supplement policy in force and does not desire to replace the existing policy or where the Medicare supplement policy would duplicate benefits to which the individual is entitled under a Medicare Advantage plan.

(3) All applications for Medicare supplement insurance shall include the right to apply for standardized Medicare supplement benefit plans "A" and "B." All applications for Medicare supplement insurance policies and certificates issued on or after June 1, 2010 shall include the right to apply for standardized Medicare supplement benefit plans "A" and "B" and either "C" or "F."

(4) In recommending the purchase or replacement of any Medicare supplement policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement. The application for Medicare supplement insurance taken by an agent shall include, or have attached thereto, a statement signed by the agent as follows:

"I have reviewed the current health insurance coverage of the applicant and find that additional coverage of the type and amount applied for is appropriate for the applicant's needs."

(5) Any sale of a Medicare supplement insurance policy or certificate that will provide an individual with more than one Medicare supplement policy or certificate or duplicate benefits to which an individual is entitled under a Medicare Advantage plan is prohibited.

(6) Application forms shall include the following questions and statements designed to elicit information as to whether, as of the date of the application, the applicant for a policy or certificate

currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another accident and health insurance policy or certificate in force and whether the Medicare supplement policy or certificate being applied for is intended to replace such existing coverage. A supplementary application or other form to be signed by the applicant containing such questions and statements may be used. Where the application is taken by an agent, such application or supplementary application form shall also be signed by the agent.

(i) Statements.

(a) You do not need more than one Medicare supplement policy or certificate.

(b) If you purchase this policy (certificate), you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(c) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy (certificate).

(d) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy (certificate) may be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (certificate) (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(e) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(f) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance available through the state Medicaid Program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB).

(ii) Questions. To the best of your knowledge and belief:
(Please mark Yes or No below with an "X")

(a)(1) Did you turn age 65 in the last 6 months?

Yes _____ No _____

(2) Did you enroll in Medicare part B in the last 6 months?

Yes _____ No _____

If yes, what is the effective date?

(b) Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)

Yes _____ No _____

If yes,

(1) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes _____ No _____

(2) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare part B premium?

Yes _____ No _____

(c)(1) If you had coverage from any Medicare Advantage plan other than original Medicare within the past 63 days (for example, a Medicare HMO, PPO or PFFS), fill in your start and end dates below. If you are still covered under the Medicare Advantage plan, leave END DATE blank.

START DATE _____ END DATE _____

(2) If you are still covered under the Medicare Advantage plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes _____ No _____

(3) Was this your first time in this type of Medicare Advantage plan?

Yes _____ No _____

(4) Did you drop a Medicare supplement policy to enroll in the Medicare Advantage plan?

Yes _____ No _____

(d)(1) Do you have another Medicare supplement or Medicare Select policy or certificate in force?

Yes _____ No _____

(2) If so, with what company, and what plan do you have?

(3) If so, do you intend to replace your current Medicare supplement or Medicare Select policy or certificate with this policy or certificate?

Yes _____ No _____

(e) Have you had coverage under any other health insurance policy or certificate within the past 63 days? (For example, an employer, union, or individual plan)

Yes _____ No _____

(1) If so, with what company and what kind of policy?

(2) What are your dates of coverage under the other policy?

START DATE _____ END DATE _____

(If you are still covered under the other policy, leave END DATE blank.)

(7) Where the application is taken by an agent, the agent shall list on the application form any other accident and health insurance policies (including Medicare supplement insurance policies) the agent has sold to the applicant. The agent shall:

(i) list all policies sold which are still in force; and

(ii) list all policies sold in the past five years which are no longer in force.

(8) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant and acknowledged by the issuer, shall be returned to the applicant by the issuer upon delivery of the policy (certificate).

(9) Where the policy or certificate contains a preexisting condition limitation, the application shall include a question to elicit information that is sufficient to allow the issuer to make a determination as to whether the applicant for the policy or certificate is eligible for a limitation credit as is provided for in section 58.1(b)(3)(ii) of this Title.

(10) With regard to individuals who are eligible for Medicare by reason of age, in no event may an issuer solicit coverage or accept applications more than 90 days prior to the month in which an individual has his or her 65th birthday.

(e) Rules relating to the replacement of health coverage with Medicare supplement insurance coverage.

(1) Upon determining that a sale of a Medicare supplement insurance or Medicare select policy or certificate will involve replacement of accident and health insurance (including Medicare supplement insurance, Medicare select or Medicare Advantage coverage), health maintenance organization coverage or any employer-provided health benefit arrangement, an issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement or Medicare select policy or certificate, a notice regarding replacement of coverage. One copy of such notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of coverage.

(2) The notice required by paragraph (1) of this subdivision for an issuer shall be provided in substantially the following form in no less than 12- point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND HEALTH INSURANCE, HMO COVERAGE OR
EMPLOYER-PROVIDED HEALTH BENEFIT ARRANGEMENT

(Insurance Company's Name and Address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished), you intend to terminate existing accident and health insurance, health maintenance organization coverage or employer-provided health benefit coverage and replace it with a policy (certificate) to be issued by (Company Name) Insurance Company. Your new policy (certificate) will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy (certificate).

You should review this new coverage carefully. Compare it with all health coverage you now have and evaluate the need for existing coverage that may duplicate this policy (certificate). Terminate your present coverage only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER, AGENT (BROKER OR OTHER REPRESENTATIVE):

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction (does) (does not) duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) checked below:

- Additional benefits
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

Other. (please specify) _____

1. Health conditions which you may presently have may be considered preexisting conditions and may not be immediately or fully covered under the new policy (certificate). This could result in denial or delay of a claim for benefits under the new policy (certificate), whereas a similar claim might have been payable under your present coverage. (This paragraph may be deleted if the replacement does not involve application of a new preexisting condition limitation.)

2. State regulation provides that in applying a preexisting condition limitation, a Medicare supplement issuer must credit the time the applicant was previously covered under creditable coverage (including Medicare supplement insurance, Medicare select coverage and Medicare Advantage plans) if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new policy or certificate. (This paragraph may be deleted if the replacement does not involve application of a new preexisting condition limitation.)

3. If you still wish to terminate your present policy or certificate and replace it with new coverage, review the application carefully before you sign it to be certain that all information has been properly recorded.

Do not cancel your present coverage until you have received your new policy (certificate) and are sure that you want to keep it.

Signature of Agent, Broker or other Representative
(Signature not required for direct response sales.)

(Insert typed name and address of issuer, agent or broker)

(Applicant's Signature)

(Date)

(3) If a Medicare supplement or Medicare select policy or certificate replaces another Medicare supplement policy or certificate, a Medicare select policy or certificate, a Medicare Advantage plan or a policy or certificate issued pursuant to a contract under section 1876 of the federal Social Security Act, then the replacing issuer must provide the policyholder or certificateholder with the following written notice:

"Your application for the Medicare supplement insurance policy (certificate) issued by this company indicates that you intended to terminate existing Medicare supplement insurance coverage, Medicare select coverage, Medicare Advantage plan or health maintenance organization (HMO) issued Medicare cost contract and replace it with the coverage applied for with this company. Duplicate coverage is unnecessary and you should terminate one of your existing coverages if more than one such plan is still in force."

At the option of the issuer, such notice shall either be included with the first premium due notice mailed to the policyholder or certificateholder after the replacement coverage is issued, or sent separately within 30 days of the date of the first premium due notice, but in no event shall such notice be provided later than six months after issuance of the replacement policy or certificate.

(f) Permitted compensation arrangements.

(1) An issuer may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(2) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five renewal years.

(3) No issuer shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing Medicare supplement insurance policy or certificate, Medicare select policy or certificate, Medicare Advantage plan or a policy or certificate issued pursuant to a contract under section 1876 of the federal Social Security Act is replaced by a Medicare supplement insurance or Medicare select policy or certificate.

(4) For purposes of this subdivision, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to, bonuses, gifts, prizes, awards and finder's fees.

(g) Standards for marketing.

(1) An issuer, directly or through its agents or other producers, shall:

(i) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(ii) Establish marketing procedures to assure excessive insurance is not sold or issued.

(iii) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

"Notice to buyer: This policy may not cover all of your medical expenses."

(iv) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and health insurance and the types and amount of any such insurance.

(v) Establish auditable procedures for verifying compliance with this subdivision.

(2) In addition to the practices prohibited in Article 24 of the Insurance Law, the following acts and practices are prohibited.

(i) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

(ii) High pressure tactics. Employing any method of marketing having the effect of or tending to

induce the purchase of insurance through force, fright, threat whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(iii) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(h) Reporting of multiple policies.

(1) On or before March 1st of each calendar year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement insurance policy or certificate:

(i) policy and certificate number;

(ii) date of issuance; and

(iii) state of issuance.

(2) The items set forth above must be grouped by individual policyholder.

(3) Issuers shall use the following reporting form to comply with the requirements of this subdivision.

FORM FOR REPORTING MULTIPLE

MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

Phone Number _____

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance	State of Issuance
-----------------------------	---------------------	----------------------

_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature

Name and Title (please type)

Date

(i) Open enrollment.

(1) An 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. Applicants must be accepted at all times throughout the year for any Medicare supplement insurance benefit plan available from an issuer.

(2) The requirements of paragraph (1) of this subdivision shall be applicable to applicants enrolled in Medicare whether enrolled by reason of age or by reason of disability.

(3) Paragraph (1) of this subdivision shall not be construed as preventing an issuer from applying a preexisting condition limitation in accordance with the requirements of subdivision (b)(3) of this section except as provided in paragraph (4) of this subdivision.

(4) The issuer of a Medicare supplement insurance policy or certificate may not impose an exclusion of benefits based upon a preexisting condition under such policy or certificate in the case of an individual described in 42 U.S.C. section 1395ss(s)(3)(B) or (F)* who seeks to enroll under the Medicare supplement insurance policy or certificate during the period specified in 42 U.S.C. section 1395ss(s)(3)(E)* and who submits evidence of the date of termination, disenrollment, or Medicare part D enrollment along with the application for such Medicare supplement insurance policy or certificate.

(j) Prohibition against use of genetic information and requests for genetic testing. This paragraph applies to all Medicare supplement insurance policies and certificates with policy years beginning on or after May 21, 2009.

(1) An issuer of a Medicare supplement policy or certificate;

(i) 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

(ii) 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.

(2) 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.

(3) Notwithstanding paragraph (2) of this subdivision, 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:

* 42 United States Code 1395ss (2007) published by the Office of Law Revision Counsel, United States House of Representatives. See www.gpoaccess.gov. It is available from the New York State Insurance Department, Office of General Counsel, 25 Beaver Street, New York, NY 10004.

(i) 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.

(ii) 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.

(iii) No genetic information collected or acquired under this subdivision 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.

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

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

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

(5) 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.

(6) 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 paragraph (5) of this subdivision if such request, requirement, or purchase is not in violation of paragraph (4) of this subdivision.

(7) For the purposes of this subdivision only:

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

(ii) *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.

(iii) *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

** Part 46 of Title 45, Code of Federal Regulations (2005) published by the Office of Law Revision Counsel, United States House of Representatives. See www.gpoaccess.gov. It is available from the New York State Insurance Department, Office of General Counsel, 25 Beaver Street, New York, NY 10004.

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, but information about the sex or age of any individual shall be used in accordance with state law or regulation.

(iv) *Genetic services* means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

(v) *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.

(vi) *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 issuance, renewal, or replacement of a contract of health insurance or health benefits.

(k) Standards for claims payment.

(1) An issuer shall comply with section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

(i) accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(ii) notifying the participating physician or supplier and the beneficiary of the payment determination;

(iii) paying the participating physician or supplier directly;

(iv) furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a Medicare carrier may be sent;

(v) paying user fees for claim notices that are transmitted electronically or otherwise; and

(vi) providing to the Secretary, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

(2) Compliance with the requirements set forth in paragraph (1) of this subdivision shall be certified on the Medicare supplement insurance experience reporting form.

(1) Filing and approval of policies and certificates and premium rates.

(1) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the superintendent in accordance with filing requirements and procedures prescribed by the superintendent.

(2) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the superintendent in accordance with the filing requirements and procedures prescribed by the superintendent.

(3)(i) A separate policy form or certificate form shall be used for each standard Medicare supplement benefit plan.

(ii) Except as provided in subparagraph (iii) of this paragraph, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(iii) An issuer may offer, with the approval of the superintendent, up to two additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(a) the inclusion of new or innovative benefits; or

(b) the addition of either direct response or agent marketing method.

(iv) For the purposes of this subdivision, a *type* means an individual policy, a group policy, an individual Medicare select policy or a group Medicare select policy.

(4) (i) The letter of submission accompanying Medicare supplement insurance policy forms and certificate forms submitted for approval shall identify the forms that the issuer intends to make available for purchase. The issuer shall also advise the superintendent in writing of its decision to make available for purchase a Medicare supplement insurance policy form or certificate form no later than 15 days after the issuer begins to offer such form for sale.

(ii) Except as provided in clause (a) of this subparagraph, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this section that has been approved by the superintendent. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the superintendent in writing its decision at least 30 days prior to discontinuing the availability of such form. After receipt of the notice by the superintendent, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to clause

(a) of this subparagraph shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the superintendent of the discontinuance. The period of discontinuance may be reduced if the superintendent determines that a shorter period is appropriate.

(iii) The sale or other transfer of Medicare supplement business to another issuer shall be considered discontinuance for the purposes of this paragraph.

(iv) A change in the rating structure or methodology shall be considered discontinuance under subparagraph (ii) of this paragraph unless the issuer complies with the following requirements:

(a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the superintendent, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(b) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. Upon request, the superintendent may approve a change to such differential which is in the public interest.

(5) As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall submit to the superintendent for the superintendent's approval, in accordance with the applicable filing requirements and procedures prescribed by the superintendent, any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

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

(1) include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement insurance policy or certificate;

(2) inform each policyholder and certificateholder as to when any premium adjustment is to be made due to changes in Medicare;

(3) be in outline form and in clear and simple terms so as to facilitate comprehension; and

(4) not contain or be accompanied by any solicitation.

(n) Notice requirements. Issuers shall comply with any notice requirements of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-173^{***}).

^{***} Pub. L. 108-173. (2007) published by the Office of Law Revision Counsel, United States House of Representatives. See www.gpoaccess.gov. It is available from the New York State Insurance Department, Office of General Counsel, 25 Beaver Street, New York, NY 10004.

Section 58.2 Rules relating to the standard Medicare supplement benefit plans and the make-up of Medicare supplement benefit plans issued for an effective date of coverage prior to June 1, 2010.

(a) General applicability. The following shall be applicable to Medicare supplement insurance and Medicare select as defined in sections 52.11 and 52.14 of this Title, respectively, and shall be in addition to other requirements of this Part. Such rules shall apply to all Medicare supplement and Medicare select policies and certificates issued with an effective date for coverage prior to June 1, 2010 in this state. 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 with an effective date for coverage on or after June 1, 2010 are subject to the requirements of section 58.4 of this Part.

(b) Standard Medicare supplement benefit plans issued with an effective date for coverage prior to June 1, 2010.

(1) 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 paragraph (6)(xi) of this subdivision.

(2) Where a nonprofit health service, hospital service or medical expense indemnity corporation issues a subscriber contract which does not include all of the benefits required for a plan of Medicare supplement insurance, such contract must, in order to qualify as Medicare supplement insurance, be issued in conjunction with another contract including the remainder of the benefits required for a plan of Medicare supplement insurance as prescribed in this section. In the alternative, two or more of such corporations may act jointly and issue a single contract which contains all of the benefits required for a plan of Medicare supplement insurance.

(3) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "L" listed in subdivision (c) of this section and conform to the definitions in section 58.1(a) of this Part. Each benefit plan shall be structured in accordance with the format provided in paragraphs (5) and (6) of this subdivision and list the benefits in the order shown in subdivision (c) of this section. For purposes of this section, structure, language, and format means style, arrangement and overall content of a benefit.

(4) An issuer may use, in addition to the benefit plan designations required in paragraph (3) of this subdivision, other designations to the extent permitted by law or regulation.

(5) Benefit plans A-J shall include the following basic "core" benefits:

(i) 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;

(ii) 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;

(iii) upon exhaustion of Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the costs incurred for hospitalization expenses of the kind covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit

of an additional 365 days. The issuer may enter into reimbursement contracts with provider hospitals to stand in the place of Medicare and to make payment for the hospitalization expenses at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, so long as there continues to be no cost to the insured person;

(iv) coverage under Medicare parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations; and

(v) 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) The following additional benefits shall be included in Medicare supplement benefit plans "B" through "J" only, as provided by subdivision (c) of this section.

(i) Medicare part A deductible: Coverage for all of the Medicare part A inpatient hospital deductible amount per benefit period.

(ii) 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.

(iii) Medicare part B deductible: Coverage for all of the Medicare part B deductible amount per calendar year regardless of hospital confinement.

(iv) 80 percent of the Medicare part B excess charges: Coverage for 80 percent 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.

(v) 100 percent of the Medicare part B excess charges: Coverage for all of the difference between the actual Medicare part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved part B charge.

(vi) Basic outpatient prescription drug benefit: Coverage for 50 percent of outpatient prescription drug charges, after a \$250 calendar year deductible, to a maximum of \$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.

(vii) Extended outpatient prescription drug benefit: Coverage for 50 percent of outpatient prescription drug charges, after a \$250 calendar year deductible to a maximum of \$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.

(viii) Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250,

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.

(ix) 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 clause (b) of this subparagraph 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 100 percent 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 (AMACPT) codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(x) 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:

(1) *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.

(2) *Care provider* means a duly qualified or licensed home health aide or 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.

(3) *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.

(4) *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 four hours in a 24-hour period of services provided by a care provider is one visit.

(b) Coverage requirements and limitations:

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

(2) 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.

(3) 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 \$40 per visit;

(iii) \$1,600 per calendar year;

(iv) seven 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; and

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

(c) Coverage is excluded for:

(1) home care visits paid for by Medicare or other government programs; and

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

(xi) New or innovative benefits: An issuer may, with the prior approval of the superintendent, 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. Such 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 benefit.

(7) (i) Every issuer shall make available both standardized Medicare supplement insurance benefit plans "A" and "B," as defined in subdivision (c)(1) and (2) of this section, to each prospective policyholder and certificateholder. An issuer may make available to prospective policyholders and certificateholders any of the other Medicare supplement insurance benefit plans permitted by this section in addition to benefit plans "A" and "B", but not in lieu thereof.

(ii) Every issuer shall permit its policyholders and certificateholders to terminate existing coverage and replace it with any other Medicare supplement insurance benefit plan then being made available to prospective policyholders and certificateholders by the issuer. An issuer may limit changes in coverage initiated by a policyholder or certificateholder to an anniversary date or other regular interval, so long as the interval is not less than once every 12 months.

(c) Make-up of Medicare supplement benefit plans issued with an effective date for coverage prior to June 1, 2010.

- (1) Standardized Medicare supplement benefit plan "A" shall be limited to the basic "core" benefits common to all benefit plans, as defined in subdivision (b)(5) of this section.
- (2) Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefits as defined in subdivision (b)(5) of this section, plus the Medicare part A deductible as defined in subdivision (b)(6)(i) of this section.
- (3) Standardized Medicare supplement benefit plan "C" shall include only the following: The core benefits as defined in subdivision (b)(5) of this section, plus the Medicare part A deductible, skilled nursing facility care, Medicare part B deductible and medically necessary emergency care in a foreign country as each is defined in subdivision (b)(6)(i), (ii), (iii) and (viii) of this section.
- (4) Standardized Medicare supplement benefit plan "D" shall include only the following: The core benefits as defined in subdivision (b)(5) of this section, plus the Medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as each is defined in subdivision (b)(6)(i), (ii), (viii) and (x) of this section.
- (5) Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefits as defined in subdivision (b)(5) of this section, plus the Medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as each is defined in subdivision (b)(6)(i), (ii), (viii) and (ix) of this section.
- (6) Standardized Medicare supplement benefit plan "F" shall include only the following: The core benefits as defined in subdivision (b)(5) of this section, plus the Medicare part A deductible, the skilled nursing facility care, the Medicare part B deductible, 100 percent of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as each is defined in subdivision (b)(6)(i), (ii), (iii), (v) and (viii) of this section.
- (7) Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100 percent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefits as defined in subdivision (b)(5) of this section, plus the Medicare part A deductible, skilled nursing facility care, the Medicare part B deductible, 100 percent of the Medicare part B excess charges and medically necessary emergency care in a foreign country as each is defined in subdivision (b)(6)(i) through (iii), (v) and (viii) of this section. 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 \$1,500 for 1998 and 1999, and shall be based on the calendar year. Such deductible shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10. For example, the annual deductible for Medicare supplement benefit high deductible plan "F" for 2010 is \$2000.
- (8) Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefits as defined in subdivision (b)(5) of this section, plus the Medicare part A deductible, skilled nursing facility care, 80 percent of the Medicare part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as each is defined in subdivision (b)(6)(i), (ii), (iv), (viii) and (x) of this section.

(9) Standardized Medicare supplement benefit plan "H" shall consist of only the following: The core benefits as defined in subdivision (b)(5) of this section, plus the Medicare part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit and medically necessary emergency care in a foreign country as each is defined in subdivision (b)(6)(i), (ii), (vi) and (viii) of this section. 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 benefits as defined in subdivision (b)(5) of this section, plus the Medicare part A deductible, skilled nursing facility care, 100 percent of the Medicare part B excess charges, basic outpatient prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as each is defined in subdivision (b)(6)(i), (ii), (v), (vi), (viii) and (x) of this section. 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 benefits as defined in subdivision (b)(5) of this section, plus the Medicare part A deductible, skilled nursing facility care, Medicare part B deductible, 100 percent of the Medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as each is defined in subdivision (b)(6)(i), (ii), (iii), (v), (vii), (viii), (ix) and (x) of this section. 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 percent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefits as defined in subdivision (b)(5) of this section, plus the Medicare part A deductible, skilled nursing facility care, Medicare part B deductible, 100 percent of the Medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as each is defined in subdivision (b)(6)(i) through (iii), (v) and (vii) through (x) of this section. 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 high deductible plan "J" deductible shall be \$1,500 for 1998 and 1999, and shall be based on a calendar year. Such deductible shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10. For example, the annual deductible for Medicare supplement benefit high deductible plan "J" for 2010 is \$2000. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(13) Standardized Medicare supplement benefit plan "K" shall include only the following:

(i) coverage of 100 percent of the part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(ii) coverage of 100 percent 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;

(iii) upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the costs incurred for hospitalization expenses of the kind covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days. The issuer may enter into reimbursement contracts with provider hospitals to stand in the place of Medicare and to make payment for the hospitalization expenses at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, so long as there continues to be no cost to the insured person;

(iv) Medicare part A deductible: Coverage for 50 percent 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) of this paragraph;

(v) skilled nursing facility care: Coverage for 50 percent 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) of this paragraph;

(vi) Hospice care: Coverage for 50 percent 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) of this paragraph;

(vii) coverage for 50 percent under Medicare part A or B, of the reasonable cost of the first three 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) of this paragraph;

(viii) except for coverage provided in subparagraph (ix) of this paragraph, coverage for 50 percent 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) of this paragraph;

(ix) coverage of 100 percent of the cost sharing for Medicare part B preventive services after the policyholder pays the part B deductible; and

(x) coverage of 100 percent 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 \$4,620 in 2010, indexed each year by the appropriate inflation adjustment specified by the Secretary.

(14) Standardized Medicare supplement benefit plan "L" shall include only the following:

(i) the benefits described in paragraph (13)(i), (ii), (iii) and (ix) of this subdivision;

(ii) the benefit described in paragraph (13)(iv), (v), (vi), (vii) and (viii) of this subdivision, but substituting 75 percent for 50 percent; and

(iii) the benefit described in paragraph (13)(x) of this subdivision, but substituting \$2,310 for \$4,620.

Section 58.3 Required disclosure statement for policies and certificates meeting definition of section 52.11 or 52.14 of this Title issued with an effective date for coverage prior to June 1, 2010.

(a) The disclosure statement required by insurers issuing policies and certificates of Medicare supplement insurance meeting the standards of sections 52.11 and 52.14 of this Title and sections 58.1 and 58.2 of this Part shall consist of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The disclosure statement shall be in the language and format prescribed below in not less than 12-point type. All benefit plans “A” through “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.

(b) No individual accident and health insurance policy shall be delivered or issued for delivery in this state, unless the appropriate disclosure form in this section is provided to the applicant at the time that the application is presented to the prospective applicant and, except for direct response insurance, written acknowledgment of receipt of the requisite disclosure statement shall be obtained from the applicant by the insurer.

(c) Insurers issuing certificates of Medicare supplement insurance for delivery in this state shall provide all applicants for such coverage with a disclosure statement in the form prescribed in this section except that all references to “policy” shall be replaced with “certificate”, where appropriate. Such disclosure statement must be provided at the time that the application is presented to the prospective applicant and, except in the case of direct response insurance, written acknowledgment of receipt of the requisite disclosure statement shall be obtained from the applicant by the insurer.

(d) If the Medicare supplement insurance policy or certificate is issued on a basis that would require revision of the disclosure statement, then a substitute disclosure statement properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in not less than 12-point type, immediately above the company name:

“NOTICE: Read this disclosure statement (outline of coverage) carefully. It is not identical to the disclosure statement (outline of coverage) provided upon application and the coverage originally applied for has not been issued.”

(e) Attached is an appendix (Appendix 12A, *infra*) containing the items that shall be included in the disclosure statement in the order prescribed therein.

Section 58.4 Rules relating to content of forms for Medicare supplement insurance policies and certificates issued with an effective date for coverage on or after June 1, 2010.

(a) General applicability. The following shall be applicable to Medicare supplement insurance and Medicare select as defined in sections 52.11 and 52.14 of this Title, respectively, and shall be in

addition to other requirements of this Part. Such rules shall apply to all Medicare supplement and Medicare select policies and certificates issued with an effective date for coverage on or after June 1, 2010 in this state. 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 with an effective date for coverage prior to June 1, 2010 remain subject to the requirements of section 58.2 of this Part.

(b) Standard Medicare supplement benefit plans issued with an effective date for coverage on or after June 1, 2010.

(1) 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 paragraph (6)(vii) of this subdivision.

(2) Where a nonprofit health service, hospital service or medical expense indemnity corporation issues a subscriber contract which does not include all of the benefits required for a plan of Medicare supplement insurance, such contract must, in order to qualify as Medicare supplement insurance, be issued in conjunction with another contract including the remainder of the benefits required for a plan of Medicare supplement insurance as prescribed in this section. In the alternative, two or more of such corporations may act jointly and issue a single contract which contains all of the benefits required for a plan of Medicare supplement insurance.

(3) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A", "B", "C", "D", "F", "F+", "G", "K", "L", "M", and "N" listed in subdivision (e) of this section and conform to the definitions in section 58.1(a) of this Part. Each benefit plan shall be structured in accordance with the format provided in paragraphs (5) and (6) of this subdivision and list the benefits in the order shown in subdivision (e) of this section. For purposes of this section, structure, language, and format means style, arrangement and overall content of a benefit.

(4) An issuer may use, in addition to the benefit plan designations required in paragraph (3) of this subdivision, other designations to the extent permitted by law or regulation.

(5) 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.

(i) 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;

(ii) 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;

(iii) Upon exhaustion of Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the costs incurred for hospitalization expenses of the kind covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days. The issuer may enter into reimbursement contracts with provider hospitals to stand in the place of Medicare and to make payment for the hospitalization expenses at the

applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, so long as there continues to be no cost to the insured person;

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

(v) 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;

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

(6) 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 subdivision (c) of this section.

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

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

(iii) 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.

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

(v) One Hundred Percent 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.

(vi) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent 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.

(vii) New or Innovative Benefits: An issuer may, with the prior approval of the superintendent, 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.

(7) (i) Every issuer shall make available both standardized Medicare supplement insurance benefit plans "A" and "B," as defined in subdivision (c)(1) and (2) of this section, to each prospective policyholder and certificateholder. On or after June 1, 2010, the issuer shall also make available to each prospective policyholder and certificateholder in addition to standardized Medicare supplement insurance benefit plans "A" and "B" as described in subdivision (c)(1) and (2) of this section, standardized Medicare supplement insurance benefit plans "C", as described in subdivision (c)(3) of this section or "F" as described in subdivision (c)(5) of this section. An issuer may make available to prospective policyholders and certificateholders any of the other Medicare supplement insurance benefit plans permitted by this section in addition to benefit plans "A" and "B" and either "C" or "F", but not in lieu thereof.

(ii) Every issuer shall permit its policyholders and certificateholders to terminate existing coverage and replace it with any other Medicare supplement insurance benefit plan then being made available to prospective policyholders and certificateholders by the issuer. An issuer may limit changes in coverage initiated by a policyholder or certificateholder to an anniversary date or other regular interval, so long as the interval is not less than once every 12 months.

(c) Make-up of Medicare supplement benefit plans issued with an effective date for coverage on or after June 1, 2010.

(1) Standardized Medicare supplement benefit plan "A" shall include only the following: The basic core benefits as defined in subdivision (b)(5) of this section.

(2) Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefits as defined in subdivision (b)(5) of this section, plus one hundred percent of the Medicare part A deductible as defined in subdivision (b)(6)(i) of this section.

(3) Standardized Medicare supplement benefit plan "C" shall include only the following: The core benefits as defined in subdivision (b)(5) of this section, plus one hundred percent of the Medicare part A deductible, skilled nursing facility care, one hundred percent of the Medicare part B deductible, and medically necessary emergency care in a foreign country as each is defined in subdivision (b)(6)(i), (iii), (iv), and (vi) of this section.

(4) Standardized Medicare supplement benefit plan "D" shall include only the following: The core benefits (as defined in subdivision (b)(5) of this section, plus one hundred percent of the Medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in an foreign country as each is defined in subdivision (b)(6)(i), (iii), and (vi) of this section.

(5) Standardized Medicare supplement plan "F" shall include only the following: The core benefits as defined in subdivision (b)(5) of this section, plus one hundred percent of the Medicare part A deductible, the skilled nursing facility care, one hundred percent of the Medicare part B deductible, one hundred percent of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as each is defined in subdivision (b)(6)(i), (iii), (iv), (v), and (vi) of this section.

(6) Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100 percent of covered expenses following payment of the annual high deductible plan "F"

deductible, the core benefits as defined in subdivision (b)(5) of this section, plus one hundred percent of the Medicare part A deductible, skilled nursing facility care, one hundred percent of the Medicare part B deductible, one hundred percent of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as each is defined in subdivision (b)(6)(i), (iii), (iv), (v), and (vi) of this section. The annual deductible for Medicare supplement benefit high deductible plan “F” shall consist of out-of-pocket expenses, other than premiums, for services covered by 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 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. For example, the annual deductible for Medicare supplement benefit high deductible plan “F” for 2010 is \$2000.

(7) Standardized Medicare supplement benefit plan “G” shall include only the following: The core benefits as defined in subdivision (b)(5) of this section, plus one hundred percent of the Medicare part A deductible, skilled nursing facility care, one hundred percent of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in subdivision (b)(6)(i), (iii), (v), and (vi) of this section.

(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:

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

(ii) Part A Hospital Coinsurance, 91st through 150th days: Coverage of one hundred percent 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;

(iii) Part A Hospitalization After Lifetime Reserve Days are Exhausted: Upon exhaustion of Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the costs incurred for hospitalization expenses of the kind covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days. The issuer may enter into reimbursement contracts with provider hospitals to stand in the place of Medicare and to make payment for the hospitalization expenses at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, so long as there continues to be no cost to the insured person;

(iv) Medicare Part A Deductible: Coverage for fifty percent 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) of this paragraph;

(v) Skilled Nursing Facility Care: Coverage for fifty percent 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) of this paragraph;

(vi) Hospice Care: Coverage for fifty percent 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) of this paragraph;

(vii) Blood: Coverage for fifty percent, 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) of this paragraph;

(viii) Part B Cost Sharing: Except for coverage provided in subparagraph (ix) coverage for fifty percent 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) of this paragraph;

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

(x) Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent 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 \$4620 in 2010, indexed each year by the appropriate inflation adjustment specified by the Secretary.

(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:

(i) The benefits described in paragraph (8)(i), (ii), (iii), and (ix) of this of this subdivision.

(ii) The benefit described in paragraph (8)(iv), (v), (vi), (vii) and (viii) of this of this subdivision, but substituting seventy-five percent for fifty percent; and

(iii) The benefit described in subparagraph (x) of this subdivision, but substituting \$2310 for \$4620.

(10) Standardized Medicare supplement plan “M” shall include only the following: The core benefits as defined in subdivision (b)(5) of this section, plus fifty percent of the Medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as each is defined in subdivision (b)(6) (ii), (iii), and (vi) of this section.

(11) Standardized Medicare supplement plan “N” shall include only the following: The core benefits as defined in subdivision (b)(5) of this section, plus one hundred percent of the Medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as each is defined in subdivision (b)(6) (i), (iii), and (vi) of this section, with copayments in the following amounts:

(i) 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

(ii) 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.

(d) Attached is an appendix (Appendix 12, *infra*) that includes the required disclosure statement for policies and certificates meeting the definition of section 52.11 or 52.14 of this Title issued with an effective date for coverage on or after June 1, 2010.

Section 58.5 Required disclosure statement for policies and certificates meeting definition of section 52.11 and 52.14 of this Title issued with an effective date for coverage on or after June 1, 2010.

(a) The disclosure statement required by an issuer of policies and certificates of Medicare supplement insurance meeting the standards of sections 52.11 and 52.14 of this Title and sections 58.1 and 58.4 of this Part shall consist of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The disclosure statement shall be in the language and format prescribed below in not less than 12-point type. All benefit plans “A” through “D”, “F”, F+”, “G”, and “K” through “N” 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.

(b) No individual accident and health insurance policy shall be delivered or issued for delivery in this state, unless the appropriate disclosure form in this section is provided to the applicant at the time that the application is presented to the prospective applicant and, except for direct response insurance, written acknowledgment of receipt of the requisite disclosure statement shall be obtained from the applicant by the issuer.

(c) Every issuer of a certificate of Medicare supplement insurance delivered or issued for delivery in this state shall provide the applicant for the coverage with a disclosure statement in the form prescribed in this section except that all references to “policy” shall be replaced with “certificate”, where appropriate. The disclosure statement must be provided at the time that the application is presented to the prospective applicant and, except in the case of direct response insurance, written acknowledgment of receipt of the requisite disclosure statement shall be obtained from the applicant by the insurer.

(d) If the Medicare supplement insurance policy or certificate is issued on a basis that would require revision of the disclosure statement, then a substitute disclosure statement properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in not less than 12-point type, immediately above the company name:

“NOTICE: Read this disclosure statement (outline of coverage) carefully. It is not identical to the disclosure statement (outline of coverage) provided upon application and the coverage originally applied for has not been issued.”

(e) Attached is an appendix (Appendix 12B, *infra*) containing the items that shall be included in the disclosure statement in the order prescribed therein.

Section 58.6 Medicare select policies and certificates.

(a) (1) This section shall apply to Medicare select policies and certificates, as defined in section 52.14 of this Title.

(2) No policy or certificate may be advertised as a Medicare select policy or certificate unless it meets the requirements of this section.

(3) Medicare select policies and certificates are subject to all of the requirements of this Part pertaining to Medicare supplement insurance except that benefits under the Medicare select policies and certificates may be restricted to items and services furnished by network providers or reduced benefits may be provided when items or services are furnished by non-network providers.

(b) 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* means 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 or certificate.

(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 superintendent within which an issuer is authorized to offer a Medicare select policy or certificate.

(c) The superintendent may authorize an issuer to offer a Medicare select policy or certificate, pursuant to this section and section 4358 of the federal Omnibus Budget Reconciliation Act (OBRA) of 1990 if the superintendent finds that the issuer has satisfied all of the requirements of this Part.

(d) 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 superintendent.

(e) A Medicare select issuer shall file a proposed plan of operation with the superintendent in a format prescribed by the superintendent. 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:

(i) 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;

- (ii) the number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:
 - (a) to deliver adequately all services that are subject to a restricted network provision; or
 - (b) to make appropriate referrals;
- (iii) there are written agreements with network providers describing specific responsibilities;
- (iv) emergency care is available 24 hours per day and seven days per week;
- (v) 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:
 - (i) the formal organizational structure;
 - (ii) the written criteria for selection, retention and removal of network providers; and
 - (iii) 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 subdivision (i) of this section; and
- (7) any other information requested by the superintendent.
- (f) (1) 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 superintendent prior to implementing the changes.
- (2) An updated list of network providers shall be filed with the superintendent at least quarterly.
- (g) 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) 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) 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:
 - (i) other Medicare supplement policies or certificates offered by the issuer;
 - (ii) other Medicare select policies or certificates offered by the issuer; and
 - (iii) Medicare risk and/or cost contracts offered by the issuer;
 - (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 Medicare 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 and certificateholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer; and
 - (7) a description of the Medicare select issuer's quality assurance program and grievance procedure.
- (j) 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 subdivision (i) of this section and that the applicant understands the restrictions of the Medicare select policy or certificate.
- (k) 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 certificate 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 and certificateholder 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 superintendent regarding its grievance procedure. The report shall be in a format prescribed by the superintendent 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) 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.
- (m) Medicare select policies and certificates shall provide for continuation of coverage in the event the Secretary 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.
- (n) 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.

A new Appendix 12A is added to read as follows:

APPENDIX 12A

Required disclosure statement for policies and certificates of Medicare supplement insurance meeting the standards of sections 52.11 and 52.14 of this Title and sections 58.1 and 58.2 of this Part issued with an effective date for coverage prior to June 1, 2010. The appendix contains the items that shall be included in the disclosure statement in the order prescribed therein.

The disclosure statement shall consist of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The disclosure statement shall be in the language and format prescribed below in not less than 12-point type. All benefit plans "A" through "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.

[COMPANY NAME]
Outline of Medicare Supplement Coverage-Cover Page: 1 of 2

Benefit Plans _____ [insert letters of plans being offered]

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

See attached benefit plan charts for details about ALL plans

Basic Benefits for Plans A - J:-

Hospitalization: Part A coinsurance plus coverage for 365 additional days in your lifetime 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 Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	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	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 Deductible
					Part B Excess (100%)	Part B Excess (80%)			Part B Excess (100%)	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	At-Home Recovery	At-Home Recovery
				Preventive Care NOT covered by Medicare						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 [\$2000] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed [\$2000]. 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, in Plans "F" and "J", the plan's separate foreign travel emergency deductible. (The calendar year high deductible for high deductible Plans "F" and "J", shall be adjusted annually by the Secretary of the United States Department of Health and Human Services. The cover page must specify the applicable deductible amount.)

[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		
	[\$4620] Out of Pocket Annual Limit***	[\$2310] 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 exceptions.

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.

DISCLOSURES (Boldface Type)

Use this outline to compare benefits and premiums among policies.

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.

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)

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 section 58.2(b)(4) of this Part.)

(Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the superintendent.)

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days (lifetime) —Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$0 \$[275] a day \$[550] a day 100% of Medicare eligible expenses \$0	\$[1100](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 \$[137.50] a day \$0	\$0 \$0 \$0	\$0 Up to \$[137.50] a day All costs
BLOOD (per calendar year) 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 coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN A

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

* Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[155] (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[155] (Part B deductible) \$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 —Durable medical equipment First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[155] (Part B deductible) \$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<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 (lifetime) —Beyond the additional 365 days</p>	<p>All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0</p>	<p>\$(1100)(Part A deductible) \$[275] a day \$[550] 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 \$[137.50] a day \$0</p>	<p>\$0 \$0 \$0</p>	<p>\$0 Up to \$[137.50] a day All costs</p>
<p>BLOOD (per calendar year) First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0 \$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 coinsurance for out-patient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

PLAN B

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

* Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days (lifetime) —Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1100](Part A deductible) \$[275] a day \$[550] 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 21 st thru 100th day 101st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
BLOOD (per calendar year) 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 coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN C

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

* Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
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 \$[155] of Medicare Approved Amounts*	\$0	\$[155] (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

HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maxi-mum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days (lifetime) —Beyond the additional 365 days</p>	<p>All but \$[1100] All but \$[275] a day</p> <p>All but \$[550] a day</p> <p>\$0</p> <p>\$0</p>	<p>\$[1100] (Part A deductible) \$[275] a day</p> <p>\$[550] a day \$0</p> <p>100% of Medicare eligible expenses</p> <p>\$0</p>	<p>\$0 \$0</p> <p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</p> <p>First 20 days 21st thru 100th day 101st day and after</p>	<p>All approved amounts All but \$[137.50] a day \$0</p>	<p>\$0 Up to \$[137.50] a day \$0</p>	<p>\$0 \$0 All costs</p>
<p>BLOOD (per calendar year) First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0 \$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 coinsurance for out-patient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

PLAN D

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

* Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN D

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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	\$0	\$1,600	

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

PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days (lifetime) —Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1100] (Part A deductible) \$[275] a day \$[550] 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 21 st thru 100 th day 101st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
BLOOD (per calendar year) 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 coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN E

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

* Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

(continued)

PLAN E

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 benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All costs

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

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90 th day 91st day and after: While using 60 Lifetime reserve days Once lifetime reserve days Are used: Additional 365 days (lifetime) Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1100] (Part A deductible) \$[275] a day \$[550] 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 day 101 st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
BLOOD (per calendar year) 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 coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

(continued)

PLAN F

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

*Once you have been billed \$[155] 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 \$[155] of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 Generally 80%	\$[155] (Part B deductible) Generally 20%	\$0 \$0
Part B excess charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$[155] of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$[155] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN F
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 \$[155] of Medicare approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
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 benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

HIGH DEDUCTIBLE PLAN F

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

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

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$2000]. 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 \$[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE, ** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90 th day 91st day and after: While using 60 Lifetime reserve days Once lifetime reserve days Are used: Additional 365 days (lifetime) Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1100] (Part A deductible) \$[275] a day \$[550] 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 day 101 st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
BLOOD (per calendar year) 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 coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

(continued)

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed \$[155] 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 benefits as Plan F after one has paid a calendar year [\$2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$2000]. 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 \$[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[155] of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 Generally 80%	\$[155] (Part B deductible) Generally 20%	\$0 \$0
Part B excess charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$[155] of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$[155] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2000] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[155] of Medicare approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare approved Amounts	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[2000] 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 benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days (lifetime) —Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1100] (Part A deductible) \$[275] a day \$[550] 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 21 st thru 100th day 101st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
BLOOD (per calendar year) 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 service	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN G

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

* Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	80%	20%
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN G

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 \$[155] of Medicare Approved Amounts*	\$0	\$0	[\$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
—Calendar year maximum	\$0	\$1,600	

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

PLAN H

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days (lifetime) —Beyond the additional 365 days</p>	<p>All but \$[1100] All but \$[275] a day</p> <p>All but \$[550] a day</p> <p>\$0</p> <p>\$0</p>	<p>\$[1100] (Part A deductible) \$[275] a day</p> <p>\$[550] a day</p> <p>100% of Medicare eligible expenses</p> <p>\$0</p>	<p>\$0 \$0</p> <p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</p> <p>First 20 days 21st thru 100th day 101st day and after</p>	<p>All approved amounts All but \$[137.50] a day \$0</p>	<p>\$0 Up to \$[137.50] a day \$0</p>	<p>\$0 \$0 All costs</p>
<p>BLOOD (per calendar year) First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0 \$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 coinsurance for out-patient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

PLAN H

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

* Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

(continued)

PLAN H

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

PLAN I

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days (lifetime) —Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1100] (Part A deductible) \$[275] a day \$[550] 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 21 st thru 100th day 101st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
BLOOD (per calendar year) 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 coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN I

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

* Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[155] (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[155] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN I
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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
—Calendar year maximum	\$0	\$1,600	

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

PLAN J

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days (lifetime) —Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1100] (Part A deductible) \$[275] a day \$[550] 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 21 st thru 100th day 101st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
BLOOD (per calendar year) 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 coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

(continued)

PLAN J

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

* Once you have been billed \$[155] 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
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance
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 \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	[\$155] (Part B deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs [\$155] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN J
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 \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	\$0	\$1,600	

(continued)

PLAN J

PARTS A & B

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 benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All costs

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

HIGH DEDUCTIBLE PLAN J

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

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

** This high deductible plan pays the same benefits as Plan J after one has paid a calendar year [\$2000] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [\$2000]. 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 \$[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days (lifetime) —Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1100] (Part A deductible) \$[275] a day \$[550] 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 21 st thru 100th day 101st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
BLOOD (per calendar year) 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 coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

(continued)

HIGH DEDUCTIBLE PLAN J

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

* Once you have been billed \$[155] 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 benefits as Plan J after one has paid a calendar year [\$2000] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [\$2000]. 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 \$[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE,** YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance
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 \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$[155] (Part B deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$[155] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

HIGH DEDUCTIBLE PLAN J

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$[155] (Part B deductible) 20%	\$0 \$0 \$0
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan —Benefit for each visit —Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit) —Calendar year maximum	\$0 \$0 \$0	Actual charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week \$1,600	Balance

(continued)

HIGH DEDUCTIBLE PLAN J

PARTS A & B

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[2000] 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 Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All costs

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

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[4620] 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 copayments 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 61 st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days (lifetime) —Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[550](50% of Part A deductible) \$[275] a day \$[550] a day 100% of Medicare eligible expenses \$0	\$[550](50% 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 \$[137.50] a day \$0	\$0 Up to \$[68.75] a day \$0	\$0 Up to \$[68.75] a day ♦ All costs
BLOOD (per calendar year) 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)

PLAN K

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

**** Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$0 Generally 80% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 10%	\$[155] (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 [\$4620])*
BLOOD First 3 pints Next \$[155] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50%♦ \$[155] (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 \$[4620] 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 \$[155] of Medicare Approved Amounts*****	\$0	\$0	\$[155] (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*.

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 \$[2310] 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 copayments 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 (lifetime) —Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[825] (75% of Part A deductible) \$[275] a day \$[550] a day 100% of Medicare eligible expenses \$0	\$[275] (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 \$[137.50] a day \$0	\$0 Up to \$[103.13] a day \$0	\$0 Up to \$[34.38] a day◆ All costs
BLOOD (per calendar year) 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)

PLAN L

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

**** Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$0 Generally 80% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 15%	\$[155] (Part B deductible)**** ♦ All costs above Medicare approved amounts Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$2310])*
BLOOD First 3 pints Next \$[155] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25%♦ \$[155] (Part B deductible)♦ Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2310] 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 \$[155] of Medicare Approved Amounts*****	\$0	\$0	\$[155] (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*.

A new Appendix 12B is added to read as follows:

APPENDIX 12B

Required disclosure statement for policies and certificates of Medicare supplement insurance meeting the standards of sections 52.11 and 52.14 of this Title and sections 58.1 and 58.4 of this Part issued with an effective date for coverage on or after June 1, 2010. The appendix contains the items that shall be included in the disclosure statement in the order prescribed therein.

The disclosure statement shall consist of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The disclosure statement shall be in the language and format prescribed below in not less than 12-point type. All benefit plans "A" through "D", "F", "F+", "G", and "K" through "N" 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.

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make available Plans “A” & “B” and either “C” or “F”. Some plans may not be available in your state.

Plans E, H, 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 in your lifetime after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital 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 \$[4620]; paid at 100% after limit reached	Out-of-pocket limit \$[2310]; 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 [\$2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$2000]. 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.

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.

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. Refer to 58.2 of this Part for the benefits and premiums of policies and certificates issued prior to June 1, 2010.

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]

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 section 58.4(b)(4) of this Part.]

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days (lifetime) —Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$0 \$[275] a day \$[550] a day 100% of Medicare eligible expenses \$0	\$[1100](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 \$[137.50] a day \$0	\$0 \$0 \$0	\$0 Up to \$[137.50] 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/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

PLAN A

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

* Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$[155] (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 80%	 All costs \$0 20%	 \$0 \$[155] (Part B deductible) \$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 —Durable medical equipment First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[155] (Part B deductible) \$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days (lifetime) —Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1100](Part A deductible) \$[275] a day \$[550] 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 21 st thru 100 th day 101st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 \$0 \$0	\$0 Up to \$[137.50] 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/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

PLAN B

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

* Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[1100]	\$[1100](Part A deductible)	\$0
61 st thru 90th day	All but \$[275] a day	\$[275] a day	\$0
91 st day and after: —While using 60 lifetime reserve days	All but \$[550] a day	\$[550] a day	\$0
—Once lifetime reserve days are used: —Additional 365 days (lifetime)	\$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 \$[137.50] a day	Up to \$[137.50] a day	\$0
101st day and after	\$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/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

PLAN C

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

* Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
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 \$[155] of Medicare Approved Amounts*	\$0	\$[155] (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

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[155] of Medicare Approved Amounts*	\$0	\$[155](Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maxi- mum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days (lifetime) —Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1100] (Part A deductible) \$[275] a day \$[550] a day \$0 100% 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 21 st thru 100th day 101st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] 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/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

PLAN D

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

* Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN D

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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (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 maxi- mum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90 th day 91st day and after: While using 60 Lifetime reserve days Once lifetime reserve days Are used: Additional 365 days (lifetime) Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1100] (Part A deductible) \$[275] a day \$[550] 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 day 101 st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] 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/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

PLAN F

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

*Once you have been billed \$[155] 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 \$[155] of Medicare Approved amounts* Remainder of Medicare Approved amounts	 \$0 Generally 80%	 \$[155] (Part B deductible) Generally 20%	 \$0 \$0
Part B excess charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$[155] of Medicare Approved amounts* Remainder of Medicare Approved amounts	 \$0 \$0 80%	 All costs \$[155] (Part B deductible) 20%	 \$0 \$0 \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN F
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 \$[155] of Medicare approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
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 benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

HIGH DEDUCTIBLE PLAN F

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

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

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$2000]. 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 \$[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2000] DEDUCTIBLE, **] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90 th day 91st day and after: While using 60 Lifetime reserve days Once lifetime reserve days Are used: Additional 365 days (lifetime) Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1100] (Part A deductible) \$[275] a day \$[550] 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 day 101 st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] 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/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed \$[155] 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 benefits as Plan F after one has paid a calendar year [\$2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$2000]. 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 \$[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2000] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[155] of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 Generally 80%	\$[155] (Part B deductible) Generally 20%	\$0 \$0
Part B excess charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$[155] of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$[155] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[155] of Medicare approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare approved Amounts	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[2000] 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 benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days (lifetime) —Beyond the additional 365 days</p>	<p>All but \$[1100]</p> <p>All but \$[275] a day</p> <p>All but \$[550] a day</p> <p>\$0</p> <p>\$0</p>	<p>\$[1100] (Part A deductible)</p> <p>\$[275] a day</p> <p>\$[550] 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 21st thru 100th day 101st day and after</p>	<p>All approved amounts</p> <p>All but \$[137.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$[137.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints 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/ coinsurance for out-patient drugs and inpatient respite care</p>	<p>Medicare copayment/coinsurance</p>	<p>\$0</p>

PLAN G

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

* Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$[155] of Medicare Approved Amounts*	\$0 \$0	All costs \$0	\$0 \$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN G

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 \$[155] of Medicare Approved Amounts*	\$0	\$0	[\$155] (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 maxi- mum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[4620] 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 61 st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days (lifetime) —Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[550](50% of Part A deductible) \$[275] a day \$[550] a day 100% of Medicare eligible expenses \$0	\$[550](50% 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 \$[137.50] a day \$0	\$0 Up to \$[68.75] a day \$0	\$0 Up to \$[68.75] a day ♦ 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 respice care	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance♦

PLAN K

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

**** Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts****	\$0	\$0	\$[155] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 80% 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 10%	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 [\$4620])*
BLOOD First 3 pints	\$0	50%	50%♦
Next \$[155] of Medicare Approved Amounts****	\$0	\$0	\$[155] (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	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 \$[4620] 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 \$[155] of Medicare Approved Amounts*****	\$0	\$0	\$(155) (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*.

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 \$[2310] 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 (lifetime) —Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[825] (75% of Part A deductible) \$[275] a day \$[550] a day 100% of Medicare eligible expenses \$0	\$[275] (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 \$[137.50] a day \$0	\$0 Up to \$[103.13] a day \$0	\$0 Up to \$[34.38] 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	75% of copayment/coinsurance	25% of copayment/coinsurance ♦

(continued)

PLAN L

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

**** Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts****	\$0	\$0	\$[155] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 80% 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 [2310])*
BLOOD First 3 pints	\$0	75%	25%♦
Next \$[155] of Medicare Approved Amounts****	\$0	\$0	\$[155] (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 \$[2310] 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 —Durable medical equipment First \$[155] of Medicare Approved Amounts***** Remainder of Medicare Approved Amounts	 100% \$0 80%	 \$0 \$0 15%	 \$0 \$[155] (Part B deductible) ♦ 5% ♦

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

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</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days (lifetime) —Beyond the additional 365 days</p>	<p>All but \$[1100]</p> <p>All but \$[275] a day</p> <p>All but \$[550] a day</p> <p>\$0</p> <p>\$0</p>	<p>\$[550](50% of Part A deductible)</p> <p>\$[275] a day</p> <p>\$[550] a day</p> <p>100% of Medicare eligible expenses</p> <p>\$0</p>	<p>\$[550](50% of Part A deductible)</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 day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$[137.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$[137.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>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>

PLAN M

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

* Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[155] (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[155] (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	100%	\$0	\$0
—Durable medical equipment First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maxi- mum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days (lifetime) —Beyond the additional 365 days	All but \$[1100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1100](Part A deductible) \$[275] a day \$[550] 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 21 st thru 100th day 101st day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] 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/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

PLAN N

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

* Once you have been billed \$[155] 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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	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.	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	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (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 \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maxi- mum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

I, James J. Wrynn, Superintendent of Insurance of the State of New York, do hereby certify that the foregoing is new Part 58 to Title 11 NYCRR (Regulation No. 193) promulgated by me on April 19, 2010, pursuant to the authority granted by the federal Social Security Act (42 U.S.C. section 1395ss) and by Sections 201, 301, 3201, 3216, 3217, 3218, 3221, 3231, 3232, and 4235, and Article 43 of the Insurance Law to take effect upon filing with the Secretary of State.

Pursuant to the provisions of the State Administrative Procedure Act, prior notice of the proposed regulation was published in the State Register on February 24, 2010. No other publication or prior notice is required by statute.

James J. Wrynn
Superintendent of Insurance

April 19, 2010