

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

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

**Basic Benefits:**

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

A	B	C	D	F	F*	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B 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 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

K	L	M	N
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
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit \$[5560]; paid at 100% after limit reached	Out-of-pocket limit \$[2780]; 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 \$[2300] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$[2300]. 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. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

**READ YOUR POLICY VERY CAREFULLY** [Boldface Type]

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

**RIGHT TO RETURN POLICY** [Boldface Type]

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

**POLICY REPLACEMENT** [Boldface Type]

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

**NOTICE** [Boldface Type]

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

[for agents:]

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

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

**COMPLETE ANSWERS ARE VERY IMPORTANT** [Boldface Type]

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

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

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 9.1D of this regulation.]

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

**Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020**

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants' **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Model Regulation to Implement the NAIC Medicare Supplement  
Insurance Minimum Standards Model Act

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G <sup>1</sup>	K	L	M	N	C	F <sup>1</sup>
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays <sup>3</sup> apply	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in [2019] <sup>2</sup>					[\$5560] <sup>2</sup>	[\$2780] <sup>2</sup>				

<sup>1</sup> Plans F and G also have a high deductible option which require first paying a plan deductible of [\$2300] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

<sup>2</sup> Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

<sup>3</sup> Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to \$20 for some office visits and up to a \$50 co-payment for emergency room visits that do not result in an inpatient admission.

**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
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies</p>			
First 60 days	All but \$[1364]	\$0	\$[1364] (Part A deductible)
61st thru 90th day	All but \$[341] a day	\$[341] a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	\$0
– Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
— Beyond the additional 365 days	\$0	\$0	All costs
<p><b>SKILLED NURSING FACILITY CARE*</b> 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>			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$[170.50] a day	\$0	Up to \$[170.50] a day
101 <sup>st</sup> day and after	\$0	\$0	All costs

**PLAN A**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>BLOOD</b> First 3 pints  Additional amounts	\$0  100%	3 pints  \$0	\$0  \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

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

**PLAN A**

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

\* Once you have been billed \$[185] 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
<b>MEDICAL EXPENSES—</b> 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 \$[185] of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	       \$0   Generally 80%	       \$0   Generally 20%	          \$[185] (Part B deductible)   \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b>  First 3 pints  Next \$[185] of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	      \$0   \$0   80%	      All costs   \$0   20%	         \$0   \$[185] (Part B deductible)   \$0
<b>CLINICAL LABORATORY</b> <b>SERVICES—TESTS FOR</b> <b>DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN A**

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[185] of Medicare Approved Amounts*	\$0	\$0	\$[185] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN B**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies</p>			
First 60 days	All but \$[1364]	\$[1364] (Part A deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$[341] a day	\$[341] a day	\$0
91 <sup>st</sup> day and after:			
—While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	\$0
—Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
<p><b>SKILLED NURSING FACILITY CARE*</b> 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>			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$[170.50] a day	\$0	Up to \$[170.50] a day
101 <sup>st</sup> day and after	\$0	\$0	All costs



**PLAN B**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	\$0

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

**PLAN B**

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

\* Once you have been billed \$[185] 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
<b>MEDICAL EXPENSES—</b> 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 \$[185] of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	  \$0  Generally 80%	  \$0  Generally 20%	  \$[185] (Part B deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b>  First 3 pints  Next \$[185] of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	 \$0  \$0  80%	 All costs  \$0  20%	 \$0  \$[185] (Part B deductible)  \$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN B**

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
-First \$[185] of Medicare Approved Amounts*	\$0	\$0	[\$185] (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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1364]	\$[1364] (Part A deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$[341] a day	\$[341] a day	\$0
91 <sup>st</sup> day and after:	All but \$[682] a day	\$[682] a day	\$0
– While using 60 lifetime reserve days			
– Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
— Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
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 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$[170.50] a day	Up to \$[170.50] a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs

**PLAN C**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	\$0

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

**PLAN C**

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

\* Once you have been billed \$[185] 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
<b>MEDICAL EXPENSES—</b> 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 \$[185] of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	  \$0  Generally 80%	  \$[185] (Part B deductible)  Generally 20%	  \$0  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b>  First 3 pints  Next \$[185] of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	 \$0  \$0  80%	 All costs  \$[185] (Part B deductible)  20%	 \$0  \$0  \$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN C**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
-First \$[185] of Medicare Approved Amounts*	\$0	[\$185] (Part B deductible)	\$0
-Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN C**

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL— NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**PLAN D**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1364]	\$[1364] (Part A deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$[341] a day	\$[341] a day	\$0
91 <sup>st</sup> day and after:			
– While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	\$0
– Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
— Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
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 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$[170.50] a day	Up to \$[170.50] a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs



**PLAN D**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	\$0

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

**PLAN D**

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

\* Once you have been billed \$[185] 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES—</b> 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 \$[185] of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	  \$0  Generally 80%	  \$0  Generally 20%	  \$[185] (Part B deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b>  First 3 pints  Next \$[185] of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	 \$0  \$0  80%	 All costs  \$0  20%	 \$0  \$[185] (Part B deductible)  \$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN D**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
-First \$[185] of Medicare Approved Amounts*	\$0	\$0	\$[185] (Part B deductible)
-Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN D**

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b>			
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 F or HIGH DEDUCTIBLE PLAN F**

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

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

[\*\*This high deductible plan pays the same benefits as Plan F after you have paid a calendar year [\$2300] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$2300]. 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 \$[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2300] DEDUCTIBLE,**] YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61<sup>st</sup> thru 90<sup>th</sup> day</p> <p>91<sup>st</sup> day and after:</p> <p>– While using 60 lifetime reserve days</p> <p>– Once lifetime reserve days are used:</p> <p>– Additional 365 days</p> <p>– Beyond the additional 365 days</p>	<p>All but \$[1364]</p> <p>All but \$[341] a day</p> <p>All but \$[682] a day</p> <p>\$0</p> <p>\$0</p>	<p>\$[1364] (Part A deductible)</p> <p>\$[341] a day</p> <p>\$[682] 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>

**PLAN F or HIGH DEDUCTIBLE PLAN F**

**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD (cont.)**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2300] DEDUCTIBLE,**] YOU PAY
<p><b>SKILLED NURSING FACILITY CARE*</b> 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>21<sup>st</sup> thru 100<sup>th</sup> day</p> <p>101<sup>st</sup> day and after</p>	<p>All approved amounts</p> <p>All but \$[170.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$[170.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p><b>BLOOD</b> First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p><b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness</p>	<p>All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care</p>	<p>Medicare co-payment/coinsurance</p>	<p>\$0</p>

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

**PLAN F or HIGH DEDUCTIBLE PLAN F**

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

\*Once you have been billed \$[185] 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 you have paid a calendar year [\$2300] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$2300]. 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 \$[2300] DEDUCTIBLE,*] PLAN PAYS	[IN ADDITION TO \$[2300] DEDUCTIBLE,**] YOU PAY
<p><b>MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT,</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment</p> <p>First \$[185] of Medicare Approved Amounts*</p> <p>Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>Generally 80%</p>	<p>\$[185] (Part B deductible)</p> <p>Generally 20%</p>	<p>\$0</p> <p>\$0</p>
<p><b>Part B excess charges</b> (Above Medicare Approved Amounts)</p>	<p>\$0</p>	<p>100%</p>	<p>\$0</p>
<p><b>BLOOD</b></p> <p>First 3 pints</p> <p>Next \$[185] of Medicare Approved Amounts*</p> <p>Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>\$0</p> <p>80%</p>	<p>All costs</p> <p>\$[185] (Part B deductible)</p> <p>20%</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>
<p><b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b></p>	<p>100%</p>	<p>\$0</p>	<p>\$0</p>

**PLAN F or HIGH DEDUCTIBLE PLAN F**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY \$[2300] DEDUCTIBLE,**] PLAN PAYS</b>	<b>[IN ADDITION TO \$[2300] DEDUCTIBLE,**] YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
-First \$[185] of Medicare Approved Amounts*	\$0	\$[185] (Part B deductible)	\$0
-Remainder of Medicare — Approved Amounts	80%	20%	\$0

**PLAN F or HIGH DEDUCTIBLE PLAN F**

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY \$[2300] DEDUCTIBLE,**] PLAN PAYS</b>	<b>[IN ADDITION TO \$[2300] DEDUCTIBLE,**] YOU PAY</b>
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>			
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 or HIGH DEDUCTIBLE 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.

[\*\*This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [\$2300] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [\$2300]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan’s separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2300] DEDUCTIBLE,**] YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61<sup>st</sup> thru 90<sup>th</sup> day</p> <p>91<sup>st</sup> day and after:</p> <p>— While using 60 lifetime reserve days</p> <p>— Once lifetime reserve days are used:</p> <p>— Additional 365 days</p> <p>— Beyond the additional 365 days</p>	<p>All but \$[1364]</p> <p>All but \$[341] a day</p> <p>All but \$[682] a day</p> <p>\$0</p> <p>\$0</p>	<p>\$[1364] (Part A deductible)</p> <p>\$[341] a day</p> <p>\$[682] 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>



**PLAN G or HIGH DEDUCTIBLE PLAN G**

**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD (cont.)**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2300] DEDUCTIBLE,**] YOU PAY
<p><b>SKILLED NURSING FACILITY CARE*</b> 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>21<sup>st</sup> thru 100<sup>th</sup> day</p> <p>101<sup>st</sup> day and after</p>	<p>All approved amounts</p> <p>All but \$[170.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$[170.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p><b>BLOOD</b></p> <p>First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p><b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited co-payment/ coinsurance for out- patient drugs and inpatient respite care</p>	<p>Medicare co-payment/ coinsurance</p>	<p>\$0</p>

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

**PLAN G or HIGH DEDUCTIBLE PLAN G**

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

\*Once you have been billed \$[185] 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 G after you have paid a calendar year [\$2300] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [\$2300]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan’s separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2300] DEDUCTIBLE,**] YOU PAY
<p><b>MEDICAL EXPENSES</b> —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</p> <p>First \$[185] of Medicare Approved Amounts*</p> <p>Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>Generally 80%</p>	<p>\$0</p> <p>Generally 20%</p>	<p>\$185 (Unless Part B deductible has been met)</p> <p>\$0</p>
<p><b>Part B Excess Charges</b> (Above Medicare Approved Amounts)</p>	\$0	100%	\$0
<p><b>BLOOD</b></p> <p>First 3 pints</p> <p>Next \$[185] of Medicare Approved Amounts*</p> <p>Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>\$0</p> <p>80%</p>	<p>All costs</p> <p>\$0</p> <p>20%</p>	<p>\$0</p> <p>\$185 (Unless Part B deductible has been met)</p> <p>\$0</p>
<p><b>CLINICAL LABORATORY SERVICES</b>—TESTS FOR DIAGNOSTIC SERVICES</p>	100%	\$0	\$0

**PLAN G or HIGH DEDUCTIBLE PLAN G**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY \$[2300] DEDUCTIBLE,]** PLAN PAYS</b>	<b>[IN ADDITION TO \$[2300] DEDUCTIBLE,]** YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$[185] of Medicare Approved Amounts*	\$0	\$0	\$185 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN G or HIGH DEDUCTIBLE PLAN G**

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY \$[2300] DEDUCTIBLE,]** PLAN PAYS</b>	<b>[IN ADDITION TO \$[2300] DEDUCTIBLE,]** YOU PAY</b>
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>			
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 K**

\* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[5560] 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 co-payment 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*
<b>HOSPITALIZATION**</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1364]	\$[682] (50% of Part A deductible)	\$[682] (50% of Part A deductible)◆
61 <sup>st</sup> thru 90th day	All but \$[341] a day	\$[341] a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	\$0
– Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
— Beyond the additional 365 days	\$0	\$0	All costs

**PLAN K**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY*</b>
<p><b>SKILLED NURSING FACILITY CARE**</b> 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>21<sup>st</sup> thru 100<sup>th</sup> day</p> <p>101<sup>st</sup> day and after</p>	<p>All approved amounts.</p> <p>All but \$[170.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$[85.25] a day (50% of Part A Coinsurance)</p> <p>\$0</p>	<p>Up to \$[85.25] a day (50% of Part A Coinsurance) ♦</p> <p>All costs</p>
<p><b>BLOOD</b></p> <p>First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>50%</p> <p>\$0</p>	<p>50%♦</p> <p>\$0</p>
<p><b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness</p>	<p>All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care</p>	<p>50% of co-payment/coinsurance</p>	<p>50% of Medicare co-payment/coinsurance♦</p>

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

**PLAN K**

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

\* Once you have been billed \$[185] 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*
<p><b>MEDICAL EXPENSES—</b> 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</p> <p>First \$[185] of Medicare Approved Amounts****</p> <p>Preventive Benefits for Medicare covered services</p> <p>Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>Generally 80% or more of Medicare Approved Amounts</p> <p>Generally 80%</p>	<p>\$0</p> <p>Remainder of Medicare Approved Amounts</p> <p>Generally 10%</p>	<p>\$[185] (Part B deductible)**** ♦</p> <p>All costs above Medicare Approved Amounts</p> <p>Generally 10% ♦</p>
<p><b>Part B Excess Charges</b> (Above Medicare Approved Amounts)</p>	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$5560])*
<p><b>BLOOD</b></p> <p>First 3 pints</p> <p>Next \$[185] of Medicare Approved Amounts****</p> <p>Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>\$0</p> <p>Generally 80%</p>	<p>50%</p> <p>\$0</p> <p>Generally 10%</p>	<p>50%♦</p> <p>\$[185] (Part B deductible)**** ♦</p> <p>Generally 10% ♦</p>
<p><b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b></p>	100%	\$0	\$0

\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[5560] 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*
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
-First \$[185] of Medicare Approved Amounts*****	\$0	\$0	\$[185] (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 \$[2780] 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*
<b>HOSPITALIZATION**</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1364]	\$[1023] (75% of Part A deductible)	\$[341] (25% of Part A deductible)◆
61st thru 90th day	All but \$[341] a day	\$[341] a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	\$0
– Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
— Beyond the additional 365 days	\$0	\$0	All costs



**PLAN L**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY*</b>
<p><b>SKILLED NURSING FACILITY CARE**</b> 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>			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100th day	All but \$[170.50] a day	Up to \$[127.88] a day (75% of Part A Coinsurance)	Up to \$[42.63] a day (25% of Part A Coinsurance)♦
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	75%	25%♦
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	75% of co-payment/coinsurance	25% of co-payment/coinsurance ♦

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

**PLAN L**

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

\* Once you have been billed \$[185] 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*
<p><b>MEDICAL EXPENSES—</b> 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</p> <p>First \$[185] of Medicare Approved Amounts****</p> <p>Preventive Benefits for Medicare covered services</p> <p>Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>Generally 80% or more of Medicare Approved Amounts</p> <p>Generally 80%</p>	<p>\$0</p> <p>Remainder of Medicare Approved Amounts</p> <p>Generally 15%</p>	<p>\$[185] (Part B deductible)**** ♦</p> <p>All costs above Medicare Approved Amounts</p> <p>Generally 5% ♦</p>
<p><b>Part B Excess Charges</b> (Above Medicare Approved Amounts)</p>	<p>\$0</p>	<p>\$0</p>	<p>All costs (and they do not count toward annual out-of-pocket limit of [\$2780])*</p>
<p><b>BLOOD</b> First 3 pints</p> <p>Next \$[185] of Medicare Approved Amounts****</p> <p>Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>\$0</p> <p>Generally 80%</p>	<p>75%</p> <p>\$0</p> <p>Generally 15%</p>	<p>25%♦</p> <p>\$[185] (Part B deductible) ♦</p> <p>Generally 5%♦</p>
<p><b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b></p>	<p>100%</p>	<p>\$0</p>	<p>\$0</p>

\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2780] 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*
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
-First \$[185] of Medicare Approved Amounts*****	\$0	\$0	\$[185] (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*.

**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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1364]	\$[682] (50% of Part A deductible)	\$[682] (50% of Part A deductible)
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$[341] a day	\$[341] a day	\$0
91 <sup>st</sup> day and after:			
– While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	\$0
– Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
— Beyond the additional 365 days	\$0	\$0	All costs

**PLAN M**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>SKILLED NURSING FACILITY CARE*</b> 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 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$[170.50] a day	Up to \$[170.50] a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

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

**PLAN M**

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

\* Once you have been billed \$[185] 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><b>MEDICAL EXPENSES—</b> 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</p> <p>First \$[185] of Medicare Approved Amounts*</p> <p>Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>Generally 80%</p>	<p>\$0</p> <p>Generally 20%</p>	<p>\$[185] (Part B deductible)</p> <p>\$0</p>
<p><b>Part B Excess Charges</b> (Above Medicare Approved Amounts)</p>	\$0	\$0	All costs
<p><b>BLOOD</b></p> <p>First 3 pints</p> <p>Next \$[185] of Medicare Approved Amounts*</p> <p>Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>\$0</p> <p>80%</p>	<p>All costs</p> <p>\$0</p> <p>20%</p>	<p>\$0</p> <p>\$[185] (Part B deductible)</p> <p>\$0</p>
<p><b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b></p>	100%	\$0	\$0

**PLAN M**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
-First \$[185] of Medicare Approved Amounts*	\$0	\$0	\$[185] (Part B deductible)
-Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN M**

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL— NOT COVERED BY MEDICARE</b>			
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 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1364]	\$[1364] (Part A deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$[341] a day	\$[341] a day	\$0
91 <sup>st</sup> day and after:			
– While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	\$0
– Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
— Beyond the additional 365 days	\$0	\$0	All costs



**PLAN N**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>SKILLED NURSING FACILITY CARE*</b> 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>21<sup>st</sup> thru 100<sup>th</sup> day</p> <p>101<sup>st</sup> day and after</p>	<p>All approved amounts</p> <p>All but \$[170.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$[170.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p><b>BLOOD</b></p> <p>First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p><b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness</p>	<p>All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare co-payment/coinsurance</p>	<p>\$0</p>

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

**PLAN N**

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

\*Once you have been billed \$[185] 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
<p><b>MEDICAL EXPENSES—</b> 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</p> <p>First \$[185] of Medicare Approved Amounts*</p> <p>Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>Generally 80%</p>	<p>\$0</p> <p>Balance, other than up to [\$20] per office visit and up to [\$50] per emergency room visit. The co-payment 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.</p>	<p>\$[185] (Part B deductible)</p> <p>Up to [\$20] per office visit and up to [\$50] per emergency room visit. The co-payment 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.</p>
<p><b>Part B Excess Charges</b> (Above Medicare Approved Amounts)</p>	\$0	\$0	All costs
<p><b>BLOOD</b></p> <p>First 3 pints</p> <p>Next \$[185] of Medicare Approved Amounts*</p> <p>Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>\$0</p> <p>80%</p>	<p>All costs</p> <p>\$0</p> <p>20%</p>	<p>\$0</p> <p>\$[185] (Part B deductible)</p> <p>\$0</p>
<p><b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b></p>	100%	\$0	\$0

**PLAN N**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
-First \$[185] of Medicare Approved Amounts*	\$0	\$0	\$[185] (Part B deductible)
-Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN N**

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL— NOT COVERED BY MEDICARE</b>			
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

E. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

- (1) Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. Section 1395 et seq.), disability income policy; or other policy identified in Section 3B of this regulation, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language:

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

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

**Section 18. Requirements for Application Forms and Replacement Coverage**

- A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

**[Statements]**

- (1) You do not need more than one Medicare supplement policy.
- (2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- (3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- (4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can 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 (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.

- (5) 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.
- (6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

**[Questions]**

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an “X”]

To the best of your knowledge,

- (1) (a) Did you turn age 65 in the last 6 months?  
Yes \_\_\_ No \_\_\_
- (b) Did you enroll in Medicare Part B in the last 6 months?  
Yes \_\_\_ No \_\_\_
- (c) If yes, what is the effective date? \_\_\_\_\_
- (2) 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,

- (a) Will Medicaid pay your premiums for this Medicare supplement policy?  
Yes \_\_\_ No \_\_\_
- (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?  
Yes \_\_\_ No \_\_\_

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

START \_\_/\_\_/\_\_ END \_\_/\_\_/\_\_

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

Yes \_\_\_ No \_\_\_

- (c) Was this your first time in this type of Medicare plan?

Yes \_\_\_ No \_\_\_

- (d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes \_\_\_ No \_\_\_

- (4) (a) Do you have another Medicare supplement policy in force?

Yes \_\_\_ No \_\_\_

- (b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

\_\_\_\_\_

- (c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes \_\_\_ No \_\_\_

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

Yes \_\_\_ No \_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

START \_\_/\_\_/\_\_ END \_\_/\_\_/\_\_

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

B. Agents shall list any other health insurance policies they have sold to the applicant.

- (1) List policies sold which are still in force.  
(2) List policies sold in the past five (5) years that are no longer in force.

- C. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.
- D. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the 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 Medicare supplement coverage.
- E. The notice required by Subsection D above for an issuer shall be provided in substantially the following form in no less than twelve (12) point type:

**NOTICE TO APPLICANT REGARDING REPLACEMENT  
OF MEDICARE SUPPLEMENT INSURANCE  
OR MEDICARE ADVANTAGE**

[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 Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

**STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:**

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- 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. [optional only for Direct Mailers. ]
- Other. (please specify) \_\_\_\_\_

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

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

\_\_\_\_\_  
(Signature of Agent, Broker or Other Representative)\*  
[Typed Name and Address of Issuer, Agent or Broker]

\_\_\_\_\_  
(Applicant's Signature)

\_\_\_\_\_  
(Date)

\*Signature not required for direct response sales.

- F. Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

#### **Section 19. Filing Requirements for Advertising**

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the Commissioner of Insurance of this state for review or approval by the commissioner to the extent it may be required under state law.

**Drafting Note:** States should examine their existing laws regarding the filing of advertisements to determine the extent to which review or approval is required.

#### **Section 20. Standards for Marketing**

- A. An issuer, directly or through its producers, shall:
  - (1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.
  - (2) Establish marketing procedures to assure excessive insurance is not sold or issued.
  - (3) 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.**”
  - (4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.
  - (5) Establish auditable procedures for verifying compliance with this Subsection A.
- B. In addition to the practices prohibited in [insert citation to state unfair trade practices act], the following acts and practices are prohibited:



- (1) 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 an insurance policy or to take out a policy of insurance with another insurer.
  - (2) 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.
  - (3) 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.
- C. The terms “Medicare Supplement,” “Medigap,” “Medicare Wrap-Around” and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

**Drafting Note:** Remember that the Unfair Trade Practice Act in your state applies to Medicare supplement insurance policies and certificates.

**Section 21. Appropriateness of Recommended Purchase and Excessive Insurance**

- A. 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.
- B. Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.
- C. An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual’s Part C coverage.

**Section 22. Reporting of Multiple Policies**

- A. On or before March 1 of each 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 policy or certificate:
  - (1) Policy and certificate number; and
  - (2) Date of issuance.
- B. The items set forth above must be grouped by individual policyholder.

**Drafting Note:** Appendix B contains a reporting form for compliance with this section.

**Section 23. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates**

- A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy.
- B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

**Drafting Note:** Although NAIC is restricted from making revisions to its models that do not conform to the Omnibus Budget Reconciliation Act of 1990, states are encouraged to consider deletion of the words “for similar benefits” in Subsection A and the words “for benefits similar to those contained in the original policy or certificate” in Subsection B. States should eliminate Paragraphs (1) and (2) (applicable to preexisting conditions) of the replacement notice required by Section 16E.

**Section 24. Prohibition Against Use of Genetic Information and Requests for Genetic Testing**

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

- A. An issuer of a Medicare supplement policy or certificate;
  - 1. Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; and
  - 2. Shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.
- B. Nothing in Subsection A shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from
  - 1. Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or
  - 2. Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group).
- C. 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.
- D. Subsection C shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with Subsection A.
- E. For purposes of carrying out Subsection D, an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.
- F. Notwithstanding Subsection C, an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:
  - (1) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.
  - (2) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that –
    - (a) Compliance with the request is voluntary; and
    - (b) Non-compliance will have no effect on enrollment status or premium or contribution amounts.

- (3) No genetic information collected or acquired under this subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.
  - (4) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted.
  - (5) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this subsection.
- G. An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.
- H. 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.
- I. If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of Subsection H if such request, requirement, or purchase is not in violation of Subsection G.
- J. For the purposes of this section only:
- (1) "Issuer of a Medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer.

**Drafting Note:** Not all states currently regulate third-party administrators. However, the Genetic Information Nondiscrimination Act of 2008 requires that third-party administrators be included in the definition of an issuer of a Medicare supplement policy or certificate.

- (2) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.
- (3) "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.
- (4) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.
- (5) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.
- (6) "Underwriting purposes" means,
  - (a) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

- (b) The computation of premium or contribution amounts under the policy;
- (c) The application of any pre-existing condition exclusion under the policy; and
- (d) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

**Section 25. Separability**

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

**Section 26. Effective Date**

This regulation shall be effective on [insert date].

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*Chronological Summary of Actions (all references are to the Proceedings of the NAIC).*

1980 Proc. II 22, 26, 588, 591, 593, 595-603 (adopted).  
1981 Proc. I 47, 51, 420, 422, 424, 466-447, 470-481 (amended and reprinted).  
1988 Proc. I 9, 20-21, 629-630, 652-654, 668-677 (amended and reprinted).  
1988 Proc. II 5, 13, 568, 601, 604, 615-624 (amended and reprinted).  
1989 Proc. I 14, 813-814, 836, 4-836.26 (amended at special plenary session September 1988).  
1989 Proc. I 9, 25, 703, 753-754, 757-760 (appendices amended at regular plenary session).  
1990 Proc. I 6, 27-28, 477, 574-576, 580-599 (amended and reprinted).  
1990 Proc. II 7, 16, 599, 656, 657 (adopted reporting form).  
1992 Proc. I 12, 16-75, 1084-1085 (amended at special plenary session in July 1991).  
1995 Proc. 1<sup>st</sup> Quarter 7, 12, 501, 575, 586, 592-615 (amended and most of model reprinted).  
1998 Proc. 1<sup>st</sup> Quarter 769, 772-799, 905 (amended).  
1998 Proc. 3<sup>rd</sup> Quarter 15, 576, 697, 701, 702-717 (amended).  
2000 Proc. 2<sup>nd</sup> Quarter 21-22, 162, 273, 275-288 (amended).  
2001 Proc. 2<sup>nd</sup> Quarter 13, 14, 118, 171, 176, 181-187 (amended).  
2004 Proc. 3<sup>rd</sup> Quarter 84, 679-681, 747, 748-866 (amended and reprinted).  
2008 Proc. 3<sup>rd</sup> Quarter 3-114 to 3-116, 4-24 to 4-26 (amended and reprinted).  
2010 Proc. 1<sup>st</sup> Quarter (technical corrections).  
2014 1<sup>st</sup> Quarter (technical revisions).  
2015 1<sup>st</sup> Quarter (technical revisions).  
2016 1<sup>st</sup> Quarter (technical revisions).  
2016 Proc. 2<sup>nd</sup> Quarter, Vol. I 113, 137-142, 325-456, 518 (amended).  
2017 1<sup>st</sup> Quarter (technical revisions).  
2018 1<sup>st</sup> Quarter (technical revisions).  
2018 4<sup>th</sup> Quarter (technical revisions).

APPENDIX A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM  
FOR CALENDAR YEAR \_\_\_\_\_

TYPE<sup>1</sup> \_\_\_\_\_ SMSBP<sup>2</sup> \_\_\_\_\_  
 For the State of \_\_\_\_\_ Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_ Person Completing Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

Line		(a) Earned Premium <sup>3</sup>	(b) Incurred Claims <sup>4</sup>
1.	Current Years' Experience		
	a. Total (all policy years)		
	b. Current year's issues <sup>5</sup>		
	c. Net (for reporting purposes = 1a-1b)		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		
4.	Refunds Last Year (Excluding Interest)		
5.	Previous Since Inception (Excluding Interest)		
6.	Refunds Since Inception (Excluding Interest)		
7.	Benchmark Ratio Since Inception ( <i>see worksheet for Ratio 1</i> )		
8.	Experienced Ratio Since Inception ( <i>Ratio 2</i> ) $\frac{\text{Total Actual Incurred Claims (line 3, col. b)}}{\text{Total Earned Prem. (line 3, col. a) - Refunds Since Inception (line 6)}}$		
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10.	Tolerance Permitted (obtained from credibility table)		

Medicare Supplement Credibility Table

Life Years Exposed		Tolerance
Since Inception		
10,000 +		0.0%
5,000 -9,999		5.0%
2,500 -4,999		7.5%
1,000 -2,499		10.0%
500 - 999		15.0%
If less than 500, no credibility.		

<sup>1</sup> Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

<sup>2</sup> "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

<sup>3</sup> Includes Modal Loadings and Fees Charged

<sup>4</sup> Excludes Active Life Reserves

<sup>5</sup> This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

**MEDICARE SUPPLEMENT REFUND CALCULATION FORM  
FOR CALENDAR YEAR \_\_\_\_\_**

TYPE<sup>1</sup> \_\_\_\_\_ SMSBP<sup>2</sup> \_\_\_\_\_  
 For the State of \_\_\_\_\_ Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_ Person Completing Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

11.	Adjustment to Incurred Claims for Credibility Ratio 3 = Ratio 2 + Tolerance	
-----	--	--

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.  
 If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims [Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6)] x Ratio 3 (line 11)	
13.	Refund = Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6) –[Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1)]	

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature \_\_\_\_\_  
 Name - Please Type \_\_\_\_\_  
 Title - Please Type \_\_\_\_\_  
 Date \_\_\_\_\_

REPORTING FORM FOR THE CALCULATION OF BENCHMARK  
RATIO SINCE INCEPTION FOR GROUP POLICIES  
FOR CALENDAR YEAR \_\_\_\_\_

TYPE<sup>1</sup> \_\_\_\_\_ SMSBP<sup>2</sup> \_\_\_\_\_  
 For the State of \_\_\_\_\_ Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_ Person Completing Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

(a) <sup>3</sup> Year	(b) <sup>4</sup> Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(o) <sup>5</sup> Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+ <sup>6</sup>		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception:  $(1 + n)/(k + m)$ : \_\_\_\_\_

- <sup>1</sup> Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
- <sup>2</sup> "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans
- <sup>3</sup> Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990, Year 2 is 1989, etc.)
- <sup>4</sup> For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
- <sup>5</sup> These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
- <sup>6</sup> To include the earned premium for all years prior to as well as the 15<sup>th</sup> year prior to the current year.

**REPORTING FORM FOR THE CALCULATION OF BENCHMARK  
RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES  
FOR CALENDAR YEAR \_\_\_\_\_**

TYPE<sup>1</sup> \_\_\_\_\_ SMSBP<sup>2</sup> \_\_\_\_\_  
 For the State of \_\_\_\_\_ Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_ Person Completing Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

(a) <sup>3</sup> Year	(b) <sup>4</sup> Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(o) <sup>5</sup> Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+ <sup>6</sup>		4.175		0.493		8.684		0.725		0.77
Total:			(k):	(l):		(m):		(n):		

Benchmark Ratio Since Inception:  $(l + n)/(k + m)$ : \_\_\_\_\_

- <sup>1</sup> Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
- <sup>2</sup> "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans
- <sup>3</sup> Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
- <sup>4</sup> For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
- <sup>5</sup> These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
- <sup>6</sup> To include the earned premium for all years prior to as well as the 15<sup>th</sup> year prior to the current year.



**APPENDIX B**

**FORM FOR REPORTING  
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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name and Title (please type)

\_\_\_\_\_  
Date

**APPENDIX C**

**DISCLOSURE STATEMENTS**

**Instructions for Use of the Disclosure Statements for  
Health Insurance Policies Sold to Medicare Beneficiaries  
that Duplicate Medicare**

1. Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when it pays:**

- Hospital or medical expenses up to the maximum stated in the policy

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that provide benefits for specified limited services.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when:**

- Any of the services covered by the policy are also covered by Medicare

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when it pays:**

- Hospital or medical expenses up to the maximum stated in the policy

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**This is not Medicare Supplement Insurance**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

Important Notice to Persons on Medicare

**THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**This is not Medicare Supplement Insurance**

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when:**

- Any expenses or services covered by the policy are also covered by Medicare

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Hospice care
- Other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

### **This is not Medicare Supplement Insurance**

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

#### **This insurance duplicates Medicare benefits when:**

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items & services

#### **Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

#### **IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

### **This is not Medicare Supplement Insurance**

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

#### **This insurance duplicates Medicare benefits when it pays:**

- The benefits stated in the policy and coverage for the same event is provided by Medicare

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.**

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].



**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice care

- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items & services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or your state [health] insurance [assistance] program [SHIP].

**Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.