**Title 3. Commerce, Community, and Economic Development.**

**Part 2. Division of Insurance.**

**Chapter 28. Life, Health, Variable, and Related Insurance.**

3 AAC 28.456(e) is amended to read:

(e) Medicare supplement benefit plans must be uniform in structure, language, designation, and format to the standardized benefit plans listed in (g) of this section and conform to the definitions under **3 AAC 28.430** [3AAC 28.340] and 3 AAC 28.510. Each benefit must be structured in accordance with the format provided in 3 AAC 28.454(m) and (n), or, in the case of plans "K" or "L," in (g)(8) or (9) of this section, and list the benefits in the order shown. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit. (Eff. 9/19/2009, Register 191; am ____/____/_____, Register _____)

**Authority:** AS 21.06.090 AS 21.42.130 AS 21.96.060

3 AAC 28.456(g)(7) is amended to read:

(7) standardized Medicare supplement benefit plan "G" must consist of the core benefit as set out in 3 AAC 28.454(m) plus the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care provided in a foreign country as set out in 3 AAC 28.454(n)(1), (3), (5), and (6); **on or after January 1, 2020, an issuer may offer a standardized benefit plan under 3 AAC**

**28.461(g)(8) to a person who was eligible for Medicare before January 1, 2020**. (Eff. 9/19/2009, Register 191; am ____/____/_____, Register _____)

**Authority:** AS 21.06.090 AS 21.42.130 AS 21.96.060

3 AAC 28.457 is amended by adding a new subsection to read:

(c) Effective January 1, 2020, an issuer may not make Plans "C," "F," or "F" with high deductible available to a newly eligible Medicare beneficiary. (Eff. 7/1/92, Register 122; am 7/12/96, Register 139; am 4/21/99, Register 150; am 9/4/2005, Register 175; am ____/____/_____, Register _____)

**Authority:** AS 21.06.090 AS 21.42.130 AS 21.96.060

3 AAC 28 is amended by adding new sections to read:

**3 AAC 28.459. Minimum benefit standards for 2020 standardized Medicare supplement benefit policies or certificates issued with an effective date of coverage on or after January 1, 2020.** (a) A Medicare supplement policy or certificate issued with an effective date of coverage on or after January 1, 2020 may not be advertised, solicited, or issued for delivery in this state, unless it meets the requirements in this section and all other applicable requirements of 3 AAC 28.410 – 3 AAC 28.510.

(b) A Medicare supplement policy or certificate issued under this section may not exclude or limit coverage for a loss due to a preexisting condition, if the loss was incurred more than six months after the effective date of coverage. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or

treatment was recommended by or received from a physician within six months before the effective date of coverage.

(c) A Medicare supplement policy or certificate issued under this section may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(d) A Medicare supplement policy or certificate issued under this section may provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with the changes.

(e) A Medicare supplement policy or certificate issued under this section may not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(f) A Medicare supplement policy or certificate issued under this section must be guaranteed renewable and

(1) the issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual;

(2) the insurer may not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation by the individual;

(3) if the Medicare supplement policy or certificate is terminated by the group policyholder and is not replaced under (5) of this subsection, the issuer shall offer each certificate holder an individual Medicare supplement policy that, at the option of the certificate holder provides for

(A) continuation of the benefits contained in the group policy; or

(B) benefits that otherwise meet the requirements of (a) - (*l*) of this section;

(4) if an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall

(A) offer the certificate holder an opportunity to convert the group policy under (3) of this subsection; or

(B) at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy; and

(5) if a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all individuals covered under the old group policy on its date of termination; coverage under the new group policy may not result in any exclusion for preexisting conditions that would have been covered under the group policy that is being replaced.

(g) The termination of a Medicare supplement policy or certificate issued under this section must be without prejudice to a continuous loss that commenced while that policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or the payment of the maximum benefits. Receipt of Medicare Part D benefits may not be considered in determining a continuous loss.

(h) A Medicare supplement policy or certificate issued under this section must provide that benefits and premiums under the policy or certificate will be suspended at the request of the policyholder or certificate holder for the period, not to exceed 24 months, in which the policyholder or certificate holder has applied for and is determined to be entitled to Medicaid

under 42 U.S.C. 1396 – 1396w-2, but only if that policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date that the policyholder or certificate holder becomes entitled to the assistance.

(i) If a suspension occurs under (h) of this section and if the policyholder or certificate holder loses entitlement to Medicaid, the policy or certificate must be automatically reinstated as of the date of the termination of that entitlement if the policyholder or certificate holder provides notice of loss of that entitlement within 90 days after the date of the loss and pays the premium attributable to the period, calculated from the date of termination of the entitlement to Medicaid.

(j) A Medicare supplement policy or certificate issued under this section must provide that benefits and premiums under the policy or certificate will be suspended at the request of the policyholder or certificate holder if the policyholder or certificate holder is entitled to benefits under 42 U.S.C. 426(b) and is covered under a group health plan as defined in 42 U.S.C. 1395y(b)(1)(A)(v).

(k) If an issuer suspends a policy under (j) of this section and if the policyholder or certificate holder subsequently loses coverage under the group health plan, the policy or certificate must be automatically reinstated as of the date of loss of group coverage if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period starting from the effective date of the termination of enrollment in the group health plan.

(*l*) Reinstatement of the coverage described in (i) and (k) of this section

(1) may not provide for any waiting period with respect to the treatment of preexisting conditions;

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

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

(m) An issuer shall make available a policy or certificate including only the basic core benefits to a prospective insured. An issuer may make available to a prospective insured Medicare supplement insurance benefit plans "A" – "D," plan "F," high deductible plan "F," plan "G," high deductible plan "G", and plans "M," and "N" in addition to the basic core benefits, but not instead of them. The basic core benefits must contain

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

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

(3) upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

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

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

(6) coverage of cost sharing for all Medicare Part A eligible hospice care and respite care expenses.

(n) The following additional benefits must be included in Medicare supplement insurance benefit plans "B" – "D," plan "F," high deductible plan "F," plan "G," high deductible plan "G," and plans "M," and "N," as set out in 3 AAC 28.461:

(1) coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

(2) coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

(3) coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;

(4) coverage for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

(5) coverage for 100 percent of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;

(6) coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician,

and medical care received in a foreign country, if the care would have been covered by Medicare if provided in the United States and if the care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250 and a lifetime maximum benefit of $50,000; for purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset. (Eff. ____/____/_____, Register _____)

**Authority:** AS 21.06.090 AS 21.42.130 AS 21.96.060

**3 AAC 28.461. Standard Medicare supplement benefit plans for 2020 standardized Medicare supplement benefit policies or certificates issued with an effective date of coverage on or after January 1, 2020.** (a) A Medicare supplement policy or certificate delivered or issued for delivery with an effective date of coverage on or after January 1, 2020 may not be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with the benefit requirements of this section.

(b) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as set out in 3 AAC 28.459(m).

(c) If an issuer makes available any of the additional benefits as set out in 3 AAC 28.459(n), or offers standardized benefit plans "K" or "L" as set out in (g)(9) and(10) of this section, the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic core benefits as set out in 3 AAC 28.459(m), a policy form or certificate form containing either standardized benefit plan "D" as set out in (g)(4) of this section or standardized benefit plan "G" as set out in (g)(7) of this section.

(d) An issuer may not offer for sale in this state a group, package, or combination of Medicare supplement benefits other than those listed in this section, except as may be permitted under (h) of this section.

(e) Medicare supplement benefit plans must be uniform in structure, language, designation, and format to the standardized benefit plans listed in (g) of this section and conform to the definitions under 3 AAC 28.430 and 3 AAC 28.510. Each benefit must be structured in accordance with the format provided in 3 AAC 28.454(m) and (n), or, in the case of plans "K" or "L," in (g)(9) or (10) of this section, and list the benefits in the order shown. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

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

(g) The 2020 standardized Medicare supplement benefit plans must adhere to the following requirements:

(1) standardized Medicare supplement benefit plan "A" must be limited to the basic core benefits, as set out in 3 AAC 28.459(m);

(2) standardized Medicare supplement benefit plan "B" must consist of the core benefit as set out in 3 AAC 28.459(m), plus the Medicare Part A deductible as set out in 3 AAC 28.459(n)(1);

(3) standardized Medicare supplement benefit plan "C" must consist of the core benefit as set out in 3 AAC 28.459(m), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, and medically necessary emergency care provided in a foreign country as set out in 3 AAC 28.459(n)(1), (3), (4), and (6);

(4) standardized Medicare supplement benefit plan "D" must consist of the core benefit as set out in 3 AAC 28.459(m), plus the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care provided in an foreign country as set out in 3 AAC 28.459(n)(1), (3), and (6);

(5) standardized Medicare supplement plan "F" must consist of the core benefit as set out in 3 AAC 28.459(m), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care provided in a foreign country as set out in 3 AAC 28.459(n)(1) and (3) – (6);

(6) standardized Medicare supplement high deductible plan "F" must consist of all of the covered expenses following the payment of the annual high deductible plan "F" deductible subject to the following:

(A) the covered expenses include the basic core benefit as set out in 3 AAC 28.459(m), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care provided in a foreign country as set out in 3 AAC 28.459(n)(1) and (3) – (6);

(B) the annual high deductible plan "F" deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and must be in addition to any other specific benefit deductibles;

(C) the annual high deductible plan "F" deductible must be $1,500 for 1999, based on the calendar year, to be adjusted annually after that by the secretary to

reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10;

(7) standardized Medicare supplement benefit plan "G" must consist of the core benefit as set out in 3 AAC 28.459(m), plus the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care provided in a foreign country as set out in 3 AAC 28.459(n)(1), (3), (5), and (6);

(8) standardized Medicare supplement high deductible plan "G" must consist of all of the covered expenses following the payment of the annual high deductible plan "G" deductible subject to the following:

(A) the covered expenses include the basic core benefit as set out in 3 AAC 459(m), plus the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care provided in a foreign country as set out in 3 AAC 28.459(n)(1) and (3) – (6);

(B) the annual high deductible plan "G" deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "G" policy and must be in addition to any other specific benefit deductibles;

(C) the annual high deductible plan "G" deductible must be $2,200 for 2017, based on the calendar year, to be adjusted annually after that by the secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10;

(9) standardized Medicare supplement plan "K" must consist of the following benefits:

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

(B) coverage of 100 percent of the Medicare Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(C) upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

(D) coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as set out in (J) of this paragraph;

(E) coverage for 50 percent of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as set out in (J) of this paragraph;

(F) coverage for 50 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as set out in (J) of this paragraph;

(G) coverage for 50 percent under Medicare Part A or Part B of the reasonable cost of the first three pints of blood, or an equivalent quantity of packed red

blood cells as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as set out in (J) of this paragraph;

(H) except for coverage provided under (I) of this paragraph, coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as set out in (J) of this paragraph;

(I) coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible;

(J) coverage of 100 percent of all cost sharing under Medicare Part A and Part B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Part A and Part B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary;

(10) standardized Medicare supplement plan "L" and must consist of the benefits set out in

(A) the provisions of (9)(A) – (C), and (I) of this subsection;

(B) the provisions of (9)(D) – (H) of this subsection, but substituting 75 percent for 50 percent in each of those subparagraphs; and

(C) the provisions of (9)(J) of this subsection, but substituting $2,000 for $4,000 in that subparagraph;

(11) standardized Medicare supplement plan "M" must consist of the core benefit as set out in 3 AAC 28.459(m), plus 50 percent of the Medicare Part A deductible, skilled

nursing facility care, and medically necessary emergency care provided in a foreign country as set out in 3 AAC 28.459(n)(2), (3), and (6);

(12) standardized Medicare supplement plan "N" must consist of the core benefit as set out in 3 AAC 28.459(m), plus100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care provided in a foreign country as set out in 3 AAC 28.459(n)(1), (3), and (6), with copayments of

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

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

(h) An issuer may, with prior approval of the director, offer a Medicare supplement policy or certificate under this section that contains new or innovative benefits, in addition to the standard benefits required in a policy or certificate issued under this section that otherwise complies with the applicable standards. The new or innovative benefits may include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. New or innovative benefits may not include an outpatient prescription drug benefit. New or innovative benefits may not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized Medicare supplement plan. (Eff. ____/____/_____, Register _____)

**Authority:** AS 21.06.090 AS 21.42.130 AS 21.96.060

3 AAC 28.490 is repealed and readopted to read:

**3 AAC 28.490. Required disclosure provisions.** (a) Medicare supplement policies and certificates must include a renewal or continuation provision. The language or specifications of the provisions must be consistent with the type of contract issued. The provisions must be appropriately captioned, must appear on the first page of the policy, and must include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

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

(c) A Medicare supplement policy or certificate may not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import.

(d) If a Medicare supplement policy or certificate contains a limitation with respect to a preexisting condition, the limitation must appear as a separate paragraph of the policy and be labeled "preexisting condition limitation."

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

(f) An issuer of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person eligible for Medicare must provide to the applicant a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services and in a type size no smaller than 12-point type. Delivery of the *Guide* must be made regardless of whether the policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates under 3 AAC 28.410 – 3 AAC 28.510. Except for a direct response issuer, delivery of the *Guide* must be made to the applicant at the time of application and acknowledgment of receipt of the *Guide* must be obtained by the issuer. A direct response issuer shall deliver the *Guide* to the applicant upon request, but not later than at the time the policy is delivered.

(g) As soon as practicable, but not later than 30 days before the annual effective date of a Medicare benefit change, an issuer shall notify its policyholders and certificate holders of modifications that the issuer has made to Medicare supplement insurance policies or certificates in a format acceptable to the director. The notice must

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

(2) inform the policyholder or certificate holder when a premium adjustment is to be made due to changes in Medicare.

(h) The notice of benefit modifications and premium adjustments must be in outline format, in clear and simple terms, to facilitate comprehension.

(i) The notice may not contain or be accompanied by any solicitation.

(j) An issuer shall provide an outline of coverage to an applicant at the time the application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant.

(k) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement, in no smaller than 12-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(*l*) For a Medicare supplement policy or certificate sold with an effective date of coverage before June l, 2010, the outline of coverage provided to an applicant under this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage must be in the language and format set out in (t) of this section in no smaller than 12-point type. Plans

"A" – "L" must be shown on the cover page and the plans offered by the issuer must be prominently identified. Premium information for plans that are offered must be shown on the cover page or immediately following the cover page and must be prominently displayed. The premium and mode must be stated for each plan that is offered to the prospective applicant. Each possible premium for the prospective applicant must be illustrated.

(m) For a Medicare supplement policy or certificate sold with an effective date of coverage before June l, 2010, as provided in 42 U.S.C. 1395e(b)(2), the dollar amount of the inpatient hospital deductible and all coinsurance amounts for plans "A" – "L" are determined annually by the secretary between September 1 and September 15 of the year preceding the year to which they will apply. As provided in 42 U.S.C. 1395*l*(b) and 1395r(a)(1), the dollar amount of the Medicare Part B deductible for plans "A" – "L" are determined annually by the secretary. Once determined, the figures are published in the Federal Register and may be obtained from the division.

(n) For a Medicare supplement policy or certificate sold with an effective date of coverage on or after June l, 2010, the outline of coverage provided to an applicant under this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage must be in the language and format set out in (u) of this section in no smaller than 12-point type. Plans "A" – "D," plan "F," high deductible plan "F," and plans "G," "K," "L," "M," and "N" must be shown on the cover page and the plans offered by the issuer must be prominently identified. Premium information for plans that are offered must be shown on the cover page or immediately following the cover page and must be prominently displayed. The premium and mode must be

stated for each plan that is offered to the prospective applicant. Each possible premium for the prospective applicant must be illustrated.

(o) For a Medicare supplement policy or certificate sold with an effective date of coverage on or after June l, 2010, as provided in 42 U.S.C. 1395e(b)(2), the dollar amount of the inpatient hospital deductible and all coinsurance amounts for plans "A" – "D," plan "F," high deductible plan "F," and plans "G," "K," "L," "M," and "N" are determined annually by the secretary between September 1 and September 15 of the year preceding the year to which they will apply. As provided in 42 U.S.C. 1395*l*(b) and 1395r(a)(1), the dollar amount of the Medicare Part B deductible for plans "A" – "D," plan "F," high deductible plan "F," and plans "G," "K," "L," "M," and "N" are determined annually by the secretary. Once determined, the figures are published in the Federal Register and may be obtained from the division.

(p) For a Medicare policy or certificate sold with an effective date of coverage on or after January 1, 2020, the outline of coverage provided to an applicant under this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage must be in the language and format set out in (w) of this section in no smaller than 12-point type. Plans "A" – "D," plan "F" high deductible plan "F," plan "G," high deductible plan "G," and plans "K," "L," "M," and "N" must be shown on the cover page and the plans offered by the issuer must be prominently identified. Premium information for plans that are offered must be shown on the cover page or immediately following the cover page and must be prominently displayed. The premium and mode must be stated for each plan that is offered to the prospective applicant. Each possible premium for the prospective applicant must be illustrated.

(q) For a Medicare supplement policy or certificate sold with an effective date of coverage on or after January l, 2020, as provided in 42 U.S.C. 1395e(b)(2), the dollar amount of the inpatient hospital deductible and all coinsurance amounts for plans "A" – "D," plan "F," high deductible plan "F," plan "G," high deductible plan "G," and plans "K," "L," "M," and "N" are determined annually by the secretary between September 1 and September 15 of the year preceding the year to which they will apply. As provided in 42 U.S.C. 1395*l*(b) and 1395r(a)(1), the dollar amount of the Medicare Part B deductible for plans "A" – "D," plan "F," high deductible plan "F," plan "G," high deductible plan "G," and plans "K," "L," "M," and "N" are determined annually by the secretary. Once determined, the figures are published in the Federal Register and may be obtained from the division.

(r) An issuer shall comply with the notice requirements of P.L. 108-173 (Medicare Prescription Drug, Improvement, and Modernization Act of 2003).

(s) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(t) For a Medicare supplement policy or certificate sold with an effective date of coverage before June l, 2010, the following items must be included in the outline of coverage in the order set out in this subsection.

**[COMPANY NAME]**
**Outline of Medicare Supplement Coverage - Cover Page: 1 of 2**
**Benefit Plans_____ [insert letters of plans being offered]**

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

See Outlines of Coverage for details about ALL plans

**Basic Benefits for Plans A - J:**
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.
Blood: First three pints of blood each year.

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

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

[+ The dollar amount to be inserted is determined annually, as described in (m) of this section, and may be obtained from the division.]

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

**Basic Benefits for Plans K and L**, which include services similar to plans A – J, but with cost-sharing for basic benefits at different levels.

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

**Plans K and L provide for different cost-sharing for items and services than plans A - J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying the excess charges.

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

[+ The dollar amount to be inserted is determined annually, as described in (m) of this section, and may be obtained from the division.]

See Outlines of Coverage for details and exceptions.

**PREMIUM INFORMATION** [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

**DISCLOSURES** [Boldface Type]

Use this outline to compare benefits and premiums among policies.

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

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

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

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

**POLICY REPLACEMENT** [Boldface Type]

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

**NOTICE** [Boldface Type]

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

A. [for agents]:

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

B. [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 as set out in 3 AAC 28.455(e).]

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

## PLAN A

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $0 | $[+] (Part A deductible) |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | $0 | Up to $[+] a day |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)

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

*Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

## PLAN A (continued)

## PARTS A & B

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

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

## PLAN B

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | $0 | Up to $[+] a day |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)

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

*Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

## PLAN B (continued)

## PARTS A & B

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

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

## PLAN C

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

*Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $[+] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $[+] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

**PLAN C (continued)**

**PARTS A & B**

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

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

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

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

## PLAN D

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

*Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

**PLAN D (continued)**

**PARTS A & B**

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

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

**PLAN D (continued)**

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

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

## PLAN E

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

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

**PLAN E (continued)**

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

*Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

**PLAN E (continued)**

**PARTS A & B**

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

**PLAN E (continued)**

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL** - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |
| ***PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare | | | |
| First $120 each calendar year | $0 | $120 | $0 |
| Additional charges | $0 | $0 | All costs |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

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

**[**Indicate Plan F or High Deductible Plan F, depending on which plan is offered: **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.

[Language for High Deductible Plan F, if offered: ****This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year $[+] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[+]. 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 | [Language for High Deductible Plan F, if offered: AFTER YOU PAY $[+] DEDUCTIBLE,**] PLAN PAYS | [Language for High Deductible Plan F, if offered: IN ADDITION TO $[+] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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.

**[**Indicate Plan F or High Deductible Plan F, depending on which plan is offered: **PLAN F or HIGH DEDUCTIBLE PLAN F (continued)]**

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

*Once you have been billed $[+] 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.

[Language for High Deductible Plan F, if offered: ****This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year $[+] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[+]. 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 | [Language for High Deductible Plan F, if offered: AFTER YOU PAY $[+] DEDUCTIBLE,**] PLAN PAYS | [Language for High Deductible Plan F, if offered: IN ADDITION TO $[+] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $[+] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | 100% | $0 |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $[+] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

[Indicate Plan F or High Deductible Plan F, depending on which plan is offered: **PLAN F or HIGH DEDUCTIBLE PLAN F (continued)**]

**PARTS A & B**

| SERVICES | MEDICARE PAYS | [Language for High Deductible Plan F, if offered: AFTER YOU PAY $[+] DEDUCTIBLE,**] PLAN PAYS | [Language for High Deductible Plan F, if offered: IN ADDITION TO $[+] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE-APPROVED SERVICES | | | |
| -Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| -Durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $[+] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |

[Indicate Plan F or High Deductible Plan F, depending on which plan is offered: **PLAN F or HIGH DEDUCTIBLE PLAN F (continued)**]

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

| SERVICES | MEDICARE PAYS | [Language for High Deductible Plan F, if offered: AFTER YOU PAY $[+] DEDUCTIBLE,**] PLAN PAYS | [Language for High Deductible Plan F, if offered: IN ADDITION TO $[+] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL** - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

## PLAN G

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

*Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | 80% | 20% |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

**PLAN G (continued)**

**PARTS A & B**

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

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

**PLAN G (continued)**

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

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

## PLAN H

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

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

**PLAN H (continued)**

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

*Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES -** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES -** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

**PLAN H (continued)**

**PARTS A & B**

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

**PLAN H (continued)**

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL** - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $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 |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

## PLAN I

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

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

**PLAN I (continued)**

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

*Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | 100% | $0 |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

**PLAN I (continued)**

**PARTS A & B**

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

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

**PLAN I (continued)**

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

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

[Indicate Plan J or High Deductible Plan J, depending on which plan is offered: **PLAN J or HIGH DEDUCTIBLE PLAN J]**

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

*A benefit period begins on the first day you receive 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.

[Language for High Deductible Plan J, if offered: ****This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year $[+] deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are $[+]. 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 | [Language for High Deductible Plan J, if offered: AFTER YOU PAY $[+] DEDUCTIBLE,**] PLAN PAYS | [Language for High Deductible Plan J, if offered: IN ADDITION TO $[+] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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.

**[**Indicate Plan J or High Deductible Plan J, depending on which plan is offered: **PLAN J or HIGH DEDUCTIBLE PLAN J (continued)]**

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

*Once you have been billed $[+] 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.

[Language for High Deductible Plan J, if offered: ****This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year $[+] deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are $[+]. 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 | [Language for High Deductible Plan J, if offered: AFTER YOU PAY $[+] DEDUCTIBLE,**] PLAN PAYS | [Language for High Deductible Plan J, if offered: IN ADDITION TO $[+] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES -** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $[+] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | 100% | $0 |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $[+] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES -** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

[Indicate Plan J or High Deductible Plan J, depending on which plan is offered: **PLAN J or HIGH DEDUCTIBLE PLAN J (continued)**]

**PARTS A & B**

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

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

[Indicate Plan J or High Deductible Plan J, depending on which plan is offered: **PLAN J or HIGH DEDUCTIBLE PLAN J (continued)**]

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

| SERVICES | MEDICARE PAYS | [Language for High Deductible Plan J, if offered: AFTER YOU PAY $[+] DEDUCTIBLE,**] PLAN PAYS | [Language for High Deductible Plan J, if offered: IN ADDITION TO $[+] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL -** NOT COVERED BY MEDICARE<br>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 |
| ***PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE<br>Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare | | | |
| First $120 each calendar year | $0 | $120 | $0 |
| Additional charges | $0 | $0 | All costs |

[+ The dollar amount to be inserted is determined annually, as described in (m) of this section, and may be obtained from the division.]

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

**PLAN K**

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

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOSPITALIZATION**** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (50% of Part A deductible) | $[+] (50% of Part A deductible)♦ |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE**** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | Up to $[+] a day♦ |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 50% | 50%♦ |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| Available as long as your doctor certifies you are terminally ill and you elect to receive these services | Generally most Medicare eligible expenses for outpatient drugs and inpatient respite care | 50% of coinsurance or copayments | 50% of coinsurance or copayments♦ |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

****Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible) ****♦ |
| Preventive Benefits for Medicare covered services | Generally 75% or more of Medicare-approved amounts | Remainder of Medicare-approved amounts | All costs above Medicare-approved amounts |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 10% | Generally 10%♦ |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs (and they do not count toward annual out-of-pocket limit of $[+]) |
| **BLOOD** | | | |
| First 3 pints | $0 | 50% | 50%♦ |
| Next $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible) ****♦ |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 10% | Generally 10%♦ |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[+] 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 (continued)**

**PARTS A & B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE-APPROVED SERVICES | | | |
| -Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| -Durable medical equipment | | | |
| First $[+] of Medicare-approved amounts***** | $0 | $0 | $[+] (Part B deductible)♦ |
| Remainder of Medicare-approved amounts | 80% | 10% | 10%♦ |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

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

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOSPITALIZATION**** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (75% of Part A deductible) | $[+] (25% of Part A deductible)♦ |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE**** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | Up to $[+] a day♦ |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 75% | 25%♦ |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| Available as long as your doctor certifies you are terminally ill and you elect to receive these services | Generally most Medicare eligible expenses for outpatient drugs and inpatient respite care | 75% of coinsurance or copayments | 25% of coinsurance or copayments♦ |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division at the address listed in the editor's note at the end of this section.]

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

****Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible)****♦ |
| Preventive Benefits for Medicare covered services | Generally 75% or more of Medicare-approved amounts | Remainder of Medicare-approved amounts | All costs above Medicare-approved amounts |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 15% | Generally 5%♦ |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | 80% | All costs (and they do not count toward annual out-of-pocket limit of $[+]) |
| **BLOOD** | | | |
| First 3 pints | $0 | 75% | 25%♦ |
| Next $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible)****♦ |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 15% | Generally 5%♦ |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[+] 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 (continued)**

**PARTS A & B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE-APPROVED SERVICES | | | |
| -Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| -Durable medical equipment | | | |
| First $[+] of Medicare-approved amounts***** | $0 | $0 | $[+] (Part B deductible)♦ |
| Remainder of Medicare-approved amounts | 80% | 15% | 5%♦ |

[+ The dollar amount to be inserted here is determined annually, as described in (m) of this section, and may be obtained from the division.]

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

(u) For a Medicare supplement policy or certificate sold with an effective date of coverage on or after June l, 2010, the following items must be included in the outline of coverage in the order set out in this subsection. The benefit chart and the "**DISCLOSURES**" paragraph in this subsection may not be used on or after June 1, 2011.

## Benefit Chart of Medicare Supplement Plans Sold With an Effective Date of Coverage On or After June 1, 2010

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

Plans E, H, I, and J are no longer available for sale.

**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 copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

| A | B | C | D | F | F* | G |
|---|---|---|---|---|---|---|
| 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 $[+] paid at 100% after limit reached | Out-of-Pocket limit $[+] 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 [+] deductible. Benefits from high deductible plan F will not until out-of-pocket expense exceed [+]. Out-of-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.

[+ The dollar amount to be inserted is determined annually, as described in (o) of this section, and may be obtained from the division.]

**PREMIUM INFORMATION** [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

**DISCLOSURES** [Boldface Type]

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates before June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.

**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.

A. [for agents]:

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

B. [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 as set out in 3 AAC 28.456(f).]

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

## PLAN A

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $0 | $[+] (Part A deductible) |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the --additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | $0 | Up to $[+] a day |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

*Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

**PLAN A (continued)**

**PARTS A & B**

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

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

**PLAN B**

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the additional --365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | $0 | Up to $[+] a day |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

[+ The dollar amount to be inserted is determined annually, as described in (o) of this section, and may be obtained from the division.]

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

*Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES –** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES -** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

**PLAN B (continued)**

**PARTS A & B**

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

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

## PLAN C

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the additional --365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

*Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $[+] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $[+] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

**PLAN C (continued)**

**PARTS A & B**

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

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

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

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

## PLAN D

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the additional --365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

*Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

**PLAN D (continued)**

**PARTS A & B**

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

**PLAN D (continued)**

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

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

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

**[**Indicate Plan F or High Deductible Plan F, depending on which plan is offered: **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.

[Language for High Deductible Plan F, if offered: ****This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year $[+] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[+]. 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 | [Language for High Deductible Plan F, if offered: AFTER YOU PAY $[+] DEDUCTIBLE,**] PLAN PAYS | [Language for High Deductible Plan F, if offered: IN ADDITION TO $[+] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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.

**[**Indicate Plan F or High Deductible Plan F, depending on which plan is offered: **PLAN F or HIGH DEDUCTIBLE PLAN F (continued)]**

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

*Once you have been billed $[+] 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.

[Language for High Deductible Plan F, if offered: ****This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year $[+] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[+]. 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 | [Language for High Deductible Plan F, if offered: AFTER YOU PAY $[+] DEDUCTIBLE,**] PLAN PAYS | [Language for High Deductible Plan F, if offered: IN ADDITION TO $[+] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES -** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | $0 | $[+] (Part B deductible) | $0 |
| First $[+] of Medicare-approved amounts* | Generally 80% | Generally 20% | $0 |
| Remainder of Medicare-approved amounts | | | |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | 100% | $0 |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $[+] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES -** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

[Indicate Plan F or High Deductible Plan F, depending on which plan is offered: **PLAN F or HIGH DEDUCTIBLE PLAN F (continued)**]

**PARTS A & B**

| SERVICES | MEDICARE PAYS | [Language for High Deductible Plan F, if offered: AFTER YOU PAY $[+] DEDUCTIBLE,**] PLAN PAYS | [Language for High Deductible Plan F, if offered: IN ADDITION TO $[+] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE-APPROVED SERVICES | | | |
| -Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| -Durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $[+] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |

[Indicate Plan F or High Deductible Plan F, depending on which plan is offered: **PLAN F or HIGH DEDUCTIBLE PLAN F (continued)**]

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

| SERVICES | MEDICARE PAYS | [Language for High Deductible Plan F, if offered: AFTER YOU PAY $[+] DEDUCTIBLE,**] PLAN PAYS | [Language for High Deductible Plan F, if offered: IN ADDITION TO $[+] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL** - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

## PLAN G

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the additional --365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

*Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| Part B Excess Charges (Above Medicare-approved amounts) | $0 | 100% | $0 |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

**PLAN G (continued)**

**PARTS A & B**

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

**PLAN G (continued)**

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

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

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

**PLAN K**

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

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOSPITALIZATION**** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (50% of Part A deductible) | $[+] (50% of Part A deductible)♦ |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE**** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | Up to $[+] a day♦ |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 50% | 50%♦ |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | 50% of copayment/coinsurance | 50% of Medicare copayment/coinsurance♦ |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

****Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **MEDICAL EXPENSES -** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible)****♦ |
| Preventive Benefits for Medicare covered services | Generally 75% or more of Medicare-approved amounts | Remainder of Medicare-approved amounts | All costs above Medicare-approved amounts |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 10% | Generally 10%♦ |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs (and they do not count toward annual out-of-pocket limit of $[+])* |
| **BLOOD** | | | |
| First 3 pints | $0 | 50% | 50%♦ |
| Next $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible)****♦ |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 10% | Generally 10%♦ |
| **CLINICAL LABORATORY SERVICES -** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[+] 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 (continued)**

**PARTS A & B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE-APPROVED SERVICES | | | |
| -Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| -Durable medical equipment | | | |
| First $[+] of Medicare-approved amounts***** | $0 | $0 | $[+] (Part B deductible)♦ |
| Remainder of Medicare-approved amounts | 80% | 10% | 10%♦ |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

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

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOSPITALIZATION**** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (75% of Part A deductible) | $[+] (25% of Part A deductible)♦ |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE**** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | Up to $[+] a day♦ |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 75% | 25%♦ |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | 75% of copayment/coinsurance | 25% of copayment/coinsurance♦ |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

****Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **MEDICAL EXPENSES -** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible)****♦ |
| Preventive Benefits for Medicare covered services | Generally 75% or more of Medicare-approved amounts | Remainder of Medicare-approved amounts | All costs above Medicare-approved amounts |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 15% | Generally 5%♦ |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs (and they do not count toward annual out-of-pocket limit of $[+])* |
| **BLOOD** | | | |
| First 3 pints | $0 | 75% | 25%♦ |
| Next $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible)♦ |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 15% | Generally 5%♦ |
| **CLINICAL LABORATORY SERVICES -** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[+] 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 (continued)**

**PARTS A & B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE-APPROVED SERVICES | | | |
| -Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| -Durable medical equipment | | | |
| First $[+] of Medicare-approved amounts***** | $0 | $0 | $[+] (Part B deductible)♦ |
| Remainder of Medicare-approved amounts | 80% | 15% | 5%♦ |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

*****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 |
|---|---|---|---|
| **HOSPITALIZATION**<br>Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (50% Part A deductible) | $[+] (50% Part A deductible) |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE**<br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE**<br>You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

****Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

**PLAN M (continued)**

**PARTS A & B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE-APPROVED SERVICES | | | |
| -Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| -Durable medical equipment | | | |
| First $[+] of Medicare-approved amounts | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **FOREIGN TRAVEL** - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

**PLAN N**

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION**<br>Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE**<br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE**<br>You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

****Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Balance, other than up to $[+] per office visit and up to $[+] per emergency room visit. The copayment of up to $[+] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. | Up to $[20] per office visit and up to $[50] per emergency room visit. The copayment of up to $[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

**PLAN N (continued)**

**PARTS A & B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE-APPROVED SERVICES | | | |
| -Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| -Durable medical equipment | | | |
| First $[+] of Medicare-approved amounts | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **FOREIGN TRAVEL** - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

[+ The dollar amount to be inserted here is determined annually, as described in (o) of this section, and may be obtained from the division.]

(v) For a Medicare supplement policy or certificate sold on or after June l, 2011, the benefit chart and the "**DISCLOSURES**" paragraph in (u) of this section are replaced with the benefit chart and the "**DISCLOSURES**" paragraph in this subsection. All the rest of the items in the outline of coverage in the order set out in (u) of this section must be included.

## Benefit Chart of Medicare Supplement Plans Sold With an Effective Date of Coverage On or After June 1, 2010

This chart shows the benefits included in each of the stand 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 copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

| A | B | C | D | F | F* | G |
|---|---|---|---|---|---|---|
| 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 $[+] paid at 100% after limit reached | Out-of-Pocket limit $[+] 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 [+] deductible. Benefits from high deductible plan F will not until out-of-pocket expense exceed [+]. Out-of-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.

[+ The dollar amount to be inserted is determined annually, as described in (o) of this section, and may be obtained from the division.]

**PREMIUM INFORMATION** [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

**DISCLOSURES** [Boldface Type]

Use this outline to compare benefits and premiums among policies.

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

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

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

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

**POLICY REPLACEMENT** [Boldface Type]

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

**NOTICE** [Boldface Type]

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

A. [for agents]:

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

B. [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 as set out in 3 AAC 28.456(f).]

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

(w) For a Medicare supplement policy or certificate with an effective date of coverage on or after January 1, 2020, the following items must be included in the outline of coverage in the order set out in this subsection.

**Benefit Chart of Medicare Supplement Plans Sold With an Effective Date of Coverage On or After**

**January 1, 2020**

This chart shows the benefits include 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.

| Benefits | Plans Available to All Applicants | | | | | | | | Medicare eligible before 2020 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | A | B | D | G* | K% | L% | M | N& | C | F* |
| Medicare Part A coinsurance and Hospital coverage (up to an additional 365 days after Medicare benefits are used up) | X | X | X | X | X | X | X | X | X | X |
| Medicare Part B coinsurance or Copayment | X | X | X | X | 50% | 75% | X | X copays apply | X | X |
| Blood (first three pints) | X | X | X | X | 50% | 75% | X | X | X | X |
| Part A hospice care coinsurance or copayment | X | X | X | X | 50% | 75% | X | X | X | X |
| Skilled nursing facility coinsurance | | | X | X | 50% | 75% | X | X | X | X |
| Medicare Part A deductible | | X | X | X | 50% | 75% | 50% | X | X | X |
| Medicare Part B deductible | | | | | | | | | X | X |
| Medicare Part B excess charges | | | | X | | | | | | X |
| Foreign travel emergency (up to plan limits) | | | X | X | | | X | X | X | X |
| Out-of-pocket limit | | | | | [+] | [+] | | | | |

* Plans F and G also have a high deductible option which require first paying a plan deductible of [+] 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.

% 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.

&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.

[+ The dollar amount to be inserted is determined annually, as described in (q) of this section, and may be obtained from the division.]

**PREMIUM INFORMATION** [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

**DISCLOSURES** [Boldface Type]

Use this outline to compare benefits and premiums among policies.

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

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

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

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

**POLICY REPLACEMENT** [Boldface Type]

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

**NOTICE** [Boldface Type]

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

A. [for agents]:

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

B. [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 as set out in 3 AAC 28.456(f).]

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

## PLAN A

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $0 | $[+] (Part A deductible) |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the --additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | $0 | Up to $[+] a day |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

*Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

**PLAN A (continued)**

**PARTS A & B**

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

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

**PLAN B**

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the additional --365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | $0 | Up to $[+] a day |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

[+ The dollar amount to be inserted is determined annually, as described in (q) of this section, and may be obtained from the division.]

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

*Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES –** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES -** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

**PLAN B (continued)**

**PARTS A & B**

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

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

## PLAN C

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the additional --365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

*Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $[+] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $[+] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

**PLAN C (continued)**

**PARTS A & B**

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

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

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

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

## PLAN D

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the additional --365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

*Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

**PLAN D (continued)**

**PARTS A & B**

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

**PLAN D (continued)**

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

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

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

**[**Indicate Plan F or High Deductible Plan F, depending on which plan is offered: **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.

[Language for High Deductible Plan F, if offered: ****This high deductible plan pays the same or offers the same benefits as Plan F after you have paid a calendar year $[+] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[+]. 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 | [Language for High Deductible Plan F, if offered: AFTER YOU PAY $[+] DEDUCTIBLE,**] PLAN PAYS | [Language for High Deductible Plan F, if offered: IN ADDITION TO $[+] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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.

**[**Indicate Plan F or High Deductible Plan F, depending on which plan is offered: **PLAN F or HIGH DEDUCTIBLE PLAN F (continued)]**

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

*Once you have been billed $[+] 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.

[Language for High Deductible Plan F, if offered: ****This high deductible plan pays the same or offers the same benefits as Plan F after you have paid a calendar year $[+] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[+]. 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 | [Language for High Deductible Plan F, if offered: AFTER YOU PAY $[+] DEDUCTIBLE,**] PLAN PAYS | [Language for High Deductible Plan F, if offered: IN ADDITION TO $[+] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES -** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | $0 | $[+] (Part B deductible) | $0 |
| First $[+] of Medicare-approved amounts* | Generally 80% | Generally 20% | $0 |
| Remainder of Medicare-approved amounts | | | |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | 100% | $0 |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts* | $0 | $[+] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES -** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

[Indicate Plan F or High Deductible Plan F, depending on which plan is offered: **PLAN F or HIGH DEDUCTIBLE PLAN F (continued)**]

**PARTS A & B**

| SERVICES | MEDICARE PAYS | [Language for High Deductible Plan F, if offered: AFTER YOU PAY $[+] DEDUCTIBLE,**] PLAN PAYS | [Language for High Deductible Plan F, if offered: IN ADDITION TO $[+] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE-APPROVED SERVICES | | | |
| -Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| -Durable medical equipment | | | |
| First $[+] of Medicare-approved amounts* | $0 | $[+] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |

[Indicate Plan F or High Deductible Plan F, depending on which plan is offered: **PLAN F or HIGH DEDUCTIBLE PLAN F (continued)**]

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

| SERVICES | MEDICARE PAYS | [Language for High Deductible Plan F, if offered: AFTER YOU PAY $[+] DEDUCTIBLE,**] PLAN PAYS | [Language for High Deductible Plan F, if offered: IN ADDITION TO $[+] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL** - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

[Indicate Plan G or High Deductible Plan G, depending on which plan is offered:

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 [+] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [+]. 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 | [Language for High Deductible Plan G, if offered: AFTER YOU PAY $[#] DEDUCTIBLE, **]<br>PLAN PAYS | [Language for High Deductible Plan G, if offered: IN ADDITION TO $[#] DEDUCTIBLE, **] YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st – 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| - While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| - Once lifetime reserve days are used: | | | |
| - Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| - Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st – 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |

| | | | |
|---|---|---|---|
| **BLOOD**<br>First 3 pints<br>Additional Amounts | <br>$0<br>100% | <br>3 pints<br>$0 | <br>$0<br>$0 |
| **HOSPICE CARE**<br>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 copayment/coinsurance | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

***__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 (continued)

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

*Once you have been billed $[+] 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 $[+] deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $[+]. 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 | [[Language for High Deductible Plan G, if offered: AFTER YOU PAY $[#] DEDUCTIBLE, **] PLAN PAYS | [Language for High Deductible Plan G, if offered: IN ADDITION TO $[#] DEDUCTIBLE, **] YOU PAY |
|---|---|---|---|
| **Medical Expenses** – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment<br>First $[+] of Medicare Approved amounts*<br>Remainder of Medicare Approved amounts | $0<br><br>Generally 80% | $0<br><br>Generally 20% | $[+] (unless Part B deductible has been met)<br>$0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | 100% | $0 |
| **BLOOD**<br>First 3 pints<br>Next $[+] of Medicare Approved amounts*<br>Remainder of Medicare Approved amounts | $0<br>$0<br><br>80% | All costs<br>$0<br><br>20% | $0<br>[$+] (Unless Part B deductible has been met)<br>$0 |
| **CLINICAL LABORATORY SERVICES** – TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

PLAN G or HIGH DEDUCTIBLE PLAN G (continued)

**PARTS A & B**

| SERVICES | MEDICARE PAYS | [[Language for High Deductible Plan G, if offered: AFTER YOU PAY $[#] DEDUCTIBLE, **] PLAN PAYS | [Language for High Deductible Plan G, if offered: IN ADDITION TO $[#] DEDUCTIBLE, **] YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE APPROVED SERVICES | | | |
| Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| Durable medical equipment | | | |
| - First $[+] of Medicare-approved amounts* | $0 | $0 | [$+] (Unless Part B deductible has been met) |
| - Remainder of Medicare-approved amounts | 80% | 20% | $0 |

PLAN G or HIGH DEDUCTIBLE PLAN G (continued)

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

| SERVICES | MEDICARE PAYS | [[Language for High Deductible Plan G, if offered: AFTER YOU PAY $[#] DEDUCTIBLE, **]<br>PLAN PAYS | [Language for High Deductible Plan G, if offered: IN ADDITION TO $[#] DEDUCTIBLE, **] YOU PAY |
|---|---|---|---|
| FOREIGN TRAVEL - NOT COVERED BY MEDICARE<br>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 |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

**PLAN K**

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

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOSPITALIZATION**<br>Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (50% of Part A deductible) | $[+] (50% of Part A deductible)♦ |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE****<br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | Up to $[+] a day♦ |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 50% | 50%♦ |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE**<br>You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | 50% of copayment/coinsurance | 50% of Medicare copayment/coinsurance♦ |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

****Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **MEDICAL EXPENSES -** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible)****♦ |
| Preventive Benefits for Medicare covered services | Generally 75% or more of Medicare-approved amounts | Remainder of Medicare-approved amounts | All costs above Medicare-approved amounts |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 10% | Generally 10%♦ |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs (and they do not count toward annual out-of-pocket limit of $[+])* |
| **BLOOD** | | | |
| First 3 pints | $0 | 50% | 50%♦ |
| Next $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible)****♦ |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 10% | Generally 10%♦ |
| **CLINICAL LABORATORY SERVICES -** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[+] 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 (continued)**

**PARTS A & B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE-APPROVED SERVICES | | | |
| -Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| -Durable medical equipment | | | |
| First $[+] of Medicare-approved amounts***** | $0 | $0 | $[+] (Part B deductible)♦ |
| Remainder of Medicare-approved amounts | 80% | 10% | 10%♦ |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

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

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOSPITALIZATION**** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (75% of Part A deductible) | $[+] (25% of Part A deductible)♦ |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE**** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | Up to $[+] a day♦ |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 75% | 25%♦ |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | 75% of copayment/coinsurance | 25% of copayment/coinsurance♦ |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

****Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **MEDICAL EXPENSES -** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible)****♦ |
| Preventive Benefits for Medicare covered services | Generally 75% or more of Medicare-approved amounts | Remainder of Medicare-approved amounts | All costs above Medicare-approved amounts |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 15% | Generally 5%♦ |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs (and they do not count toward annual out-of-pocket limit of $[+])* |
| **BLOOD** | | | |
| First 3 pints | $0 | 75% | 25%♦ |
| Next $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible)♦ |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 15% | Generally 5%♦ |
| **CLINICAL LABORATORY SERVICES -** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[+] 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 (continued)**

**PARTS A & B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE-APPROVED SERVICES | | | |
| -Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| -Durable medical equipment | | | |
| First $[+] of Medicare-approved amounts***** | $0 | $0 | $[+] (Part B deductible)♦ |
| Remainder of Medicare-approved amounts | 80% | 15% | 5%♦ |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

*****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 |
|---|---|---|---|
| **HOSPITALIZATION**<br>Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (50% Part A deductible) | $[+] (50% Part A deductible) |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE**<br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE**<br>You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

****Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

**PLAN M (continued)**

**PARTS A & B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE-APPROVED SERVICES | | | |
| -Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| -Durable medical equipment | | | |
| First $[+] of Medicare-approved amounts | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **FOREIGN TRAVEL** - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

**PLAN N**

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION**<br>Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[+] | $[+] (Part A deductible) | $0 |
| 61st - 90th day | All but $[+] a day | $[+] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[+] a day | $[+] a day | $0 |
| --Once lifetime reserve days are used: | | | |
| --Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE**<br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st - 100th day | All but $[+] a day | Up to $[+] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE**<br>You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)**

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

****Once you have been billed $[+] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Balance, other than up to $[+] per office visit and up to $[+] per emergency room visit. The copayment of up to $[+] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. | Up to $[20] per office visit and up to $[50] per emergency room visit. The copayment of up to $[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[+] of Medicare-approved amounts**** | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

**PLAN N (continued)**

**PARTS A & B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE-APPROVED SERVICES | | | |
| -Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| -Durable medical equipment | | | |
| First $[+] of Medicare-approved amounts | $0 | $0 | $[+] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **FOREIGN TRAVEL** - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

[+ The dollar amount to be inserted here is determined annually, as described in (q) of this section, and may be obtained from the division.]

(Eff. 3/26/82, Register 81; am 8/8/90, Register 115; am 7/1/92, Register 122; am 12/4/94, Register 132; am 7/12/96, Register 139; am 4/21/99, Register 150; am 7/12/2000, Register 155; am 9/4/2005, Register 175; am 9/19/2009, Register 191)

**Authority:** AS 21.06.090 AS 21.42.130 AS 21.96.060

**Editor's note:** The information contained in the Federal Register described in **3 AAC 28.490(m), (o), and (q)** [3 AAC 28.490(m) and (o)] or a copy of the current *Guide to Health Insurance for People with Medicare* referenced in the outlines of coverage listed in **3 AAC 28.490(t) – (w)** [3 AAC 28.490(r) and (s)] may be obtained by writing to the Division of Insurance, P.O. Box 110805, Juneau, Alaska 99811-0805.

3 AAC 28.510 is amended by adding new a new paragraph to read:

(21) "newly eligible Medicare beneficiary" has the meaning given in 42 U.S.C. 1395ss(z) (section 401 of the Medicare Access and CHIP Reauthorization Act of 2015).

(Eff. 3/26/82, Register 81; am 8/8/90, Register 115; am 7/1/92, Register 122; am 7/12/96, Register 139; am 4/21/99, Register 150; am 9/4/2005, Register 175; am 9/19/2009, Register 191; am ____/____/_____, Register ____)

**Authority:** AS 21.06.090 AS 21.42.130 AS 21.96.060