

**DISTRICT OF COLUMBIA OFFICE OF ADMINISTRATIVE HEARINGS**

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**DISTRICT OF COLUMBIA RENTAL HOUSING COMMISSION**

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**NOTICE OF EMERGENCY AND PROPOSED RULEMAKING**

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The Chief Administrative Law Judge of the Office of Administrative Hearings (“OAH”), and the District of Columbia Rental Housing Commission, pursuant to the authority set forth in Section 8 of the Office of Administrative Hearings Establishment Act of 2001, effective March 6, 2002 (D.C. Law 14-76, D.C. Official Code § 2-1831.05(b)(7)), and section 202(a)(1) of the Rental Housing Act of 1985, D.C. Law 6-10, effective July 17, 1985 (D.C. Law 6-10; D.C. Official Code § 42-3502.02(a)) jointly give notice of the adoption, on an emergency basis, of the following amendments to Chapter 29 of Title 1 of the District of Columbia Municipal Regulations (DCMR).

These rules require service of orders in rental housing cases to be by first class mail, with an appropriate certificate of service. The change is necessary to conform to the Office of Administrative Hearings Mailing Certification Emergency Amendment Act of 2009, passed as sections 3010 and 3011 of the Fiscal Year 2010 Budget Support Emergency Act of 2009, D.C. Act No. 18-187 (August 26, 2009). Adoption of these rules on an emergency basis is necessary so that the rules accurately will reflect the requirements of existing law. Therefore, adoption of these rules on an emergency basis is necessary to protect public health, safety and welfare.

These emergency rules were adopted on September 16, 2009, and became effective on that date. They will expire 120 days after their adoption, or upon publication of a notice of final rulemaking in the *D.C. Register*, whichever occurs first.

The Chief Administrative Law Judge and the Rental Housing Commission also give notice of their intent to take final rulemaking action to adopt these rules as an amendment to Chapter 29 of Title 1 DCMR not less than thirty (30) days from the date of publication of this notice in the *D.C. Register* in accordance with § 6(a) of the District of Columbia Administrative Procedure Act, D.C. Official Code § 2-505(a).

**Section 2922.1 of 1 DCMR Chapter 29 is amended to read as follows:**

2922.1 Upon receipt of a petition, the Office of Administrative Hearings shall, by first-class mail, notify the adverse parties named in the petition of their right to make a written request for a hearing on the petition within 15 days after receipt of the notice.

**Section 2922.3 of 1 DCMR Chapter 29 is amended to read as follows:**

2922.3 In the case of petitions filed by a housing provider, the housing provider shall provide for each tenant in the housing accommodation one (1) copy of the petition, and an envelope, with first-class postage prepaid, addressed to each tenant by name and containing the return address of the Office of Administrative Hearings. The Office of Administrative Hearings shall mail the copies to each tenant.

**Section 2923.1 of 1 DCMR Chapter 29 is amended to read as follows:**

2923.1 If a hearing is timely requested by any party, the Office of Administrative Hearings shall send notice of the time and place of the hearing by first-class mail at least 15 days before the commencement of the hearing. The notice shall inform each party of the party's right to retain legal counsel to represent the party at the hearing.

**Section 2928.7 of 1 DCMR Chapter 29 is amended to read as follows:**

2928.7 A certificate of service shall be filed with every order issued and every document filed. The certificate of service shall state the date of service, the persons served, the address at which service was made, the manner of service and the person who served the order or document.

**Section 2936.1 of 1 DCMR Chapter 29 is amended to read as follows:**

2936.1 The Office of Administrative Hearings shall serve all final orders in rental housing cases upon the parties by first-class mail.

Comments on these proposed rules should be submitted in writing to Ms. Beverly Rivers, Esq., General Counsel, Office of Administrative Hearings, 441 4<sup>th</sup> Street, N.W., Suite 870-North, Washington, DC 20001-2714, within thirty (30) days of the publication of this notice in the *D.C. Register*. Copies of these proposed rules are available without charge at that address.

## OFFICE OF THE ATTORNEY GENERAL

**NOTICE OF EMERGENCY AND PROPOSED RULEMAKING**

The Attorney General for the District of Columbia (Attorney General), pursuant to section 9 of the District of Columbia Poverty Lawyer Loan Assistance Repayment Program Act of 2006 (Act), effective March 2, 2007, D.C. Law 16-203, D.C. Official Code § 1-308.21 *et seq.* (2009 Supp.), and Mayor's Order 2006-161, dated November 8, 2006, hereby gives notice of the adoption, on an emergency basis, of the following amendment to section 2499.1 of Title 1 of the *District of Columbia Municipal Regulations* (DCMR). This amendment updates the existing definition of "eligible debt" to clarify that "eligible debt" for the purpose of the District of Columbia Poverty Lawyer Loan Assistance Repayment Program (Program) is limited to debt incurred for reasonable educational expenses associated with attendance at and enrollment in law school for the purpose of obtaining a law degree. This clarification was recommended by the Office of the Inspector General in connection with a recent audit of the Program. Adoption of the amendment on an emergency basis is necessary to ensure that the definition, as clarified, can be applied to loans made pursuant to the Program during Fiscal Year 2010. The emergency rule was adopted on September 18, 2009 and shall remain in effect for up to one hundred twenty (120) days, until January 15, 2010, unless superseded by another rulemaking notice.

The Attorney General also gives notice of his intent to take final rulemaking action to adopt this rule in not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

**Section 2499.1 of Title 1 DCMR is amended as follows:****The definition of "eligible debt" is amended to read as follows:**

Eligible debt – outstanding principal, interest, and related expenses from loans obtained for reasonable educational expenses associated with attendance at and enrollment in law school for the purpose of obtaining a law degree, made by government and commercial lending institutions or educational institutions, but not loans extended by a private individual or group of individuals, including families.

All persons desiring to comment on the subject matter of this proposed rulemaking should file comments in writing within thirty (30) days after the date of publication of this notice in the *D.C. Register*. Comments should be filed with Eric Pookrum, Assistant Attorney General, Office of Partnerships and Grant Services, 1350 Pennsylvania Avenue, N.W., Washington, D.C. 20004. Copies of these proposed rules may also be obtained without charge at this address.

## DEPARTMENT OF INSURANCE, SECURITIES AND BANKING

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Commissioner of the Department of Insurance, Securities and Banking (“Commissioner”), pursuant to the authority set forth in sections 4, 5, 6, 9, and 11 of the Medicare Supplement Insurance Minimum Standards Act of 1992, effective July 22, 1992 (D.C. Law 9-170; D.C. Official Code §§ 31-3703, 31-3704, 31-3705, 31-3708 and 31-3710 (2001), and section 4 of Department of Insurance and Securities Regulation Establishment Act of 1996, effective May 21, 1997 (D.C. Law 11-268; D.C. Official Code § 31-103 (2009 Supp.)), hereby gives notice of the adoption of the following amendments to Chapter 22 (Medicare Supplement Insurance Minimum Standards) of Title 26 (Insurance) of the District of Columbia Municipal Regulations (“DCMR”).

The proposed amendments, if adopted, would amend the Medicare Supplement Insurance Minimum Standards to implement the National Association of Insurance Commissioners’ 2008 revisions to the Medicare Supplement Minimum Standards Model Act.

Emergency action is necessary to ensure the District’s regulations regarding standards for Medicare supplement insurance conform to federal standards and for the immediate need for the preservation of certain regulatory programs. Without this emergency action, the District of Columbia may not maintain certification of its regulatory programs, thereby resulting in an adverse affect of the health, safety, and welfare of the residents of the District of Columbia.

These emergency rules were adopted on July 1, 2009, and took effect on that date. The emergency rules will expire 120 days from the date of adoption or upon publication of a Notice of Final Rulemaking in the *D.C. Register*. The Commissioner also gives notice of his intent to adopt these proposed rules in not less than thirty (30) days after the date of the publication of this notice in the *D.C. Register*, or upon their approval by the Council pursuant to section 11(a) of the Medicare Supplement Insurance Minimum Standards Act of 1992 (D.C. Official Code § 31-3710(a)), whichever occurs later.

Chapter 22 of Title 26 of the DCMR is amended as follows:

Subsection 2205.1 is amended to read as follows:

2205.1        Except for permitted preexisting condition clauses as described in subsection 2206.4, 2207.4, and 2207a.4 of this chapter, no policy or certificate may be advertised, solicited, or issued for delivery in the District as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

Subsection 2205.4 is amended to read as follows:

2205.4 Subject to subsections 2206.7, 2206.8, 2206.13, 2207.7, and 2207.8, a Medicare supplement insurance policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

Subsection 2206.6 is amended to read as follows:

2206.6 A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

Section 2207 is amended to read as follows:

**2207 MINIMUM BENEFIT STANDARDS FOR POLICIES OR CERTIFICATES ISSUED OR DELIVERED ON OR AFTER MAY 1, 1999 AND PRIOR TO JUNE 1, 2010**

Subsection 2207.1 is amended to read as follows:

2207.1 The standards contained in this section are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in the District of Columbia on or after May 1, 1999, and prior to June 1, 2010.

Subsection 2207.6 is amended to read as follows:

2207.6 A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

Subsections 2207.14 through 2207.17 are renumbered 2207.15 through 2207.18.

A new subsection 2207.14 is added to read as follows:

2207.14 If an insurer makes a written offer to the Medicare supplement policyholders or certificate holders of one or more of its plans, to exchange during a specified period from his or her 1990 standardized plan as described in Section 2208 of this chapter to a 2010 standardized plan as described in Section 2208a of this chapter, the offer and subsequent exchange shall comply with the following requirements:

- (a) An issuer need not provide justification to the Commissioner if the insured replaces a 1990 standardized policy or certificate with an issue age rated 2010 standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the Commissioner according to the District's rate filing procedure.
- (b) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.
- (c) An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 standardized policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six (6) months to any added benefits contained in the new 2010 standardized policy or certificate not contained in the exchanged policy.
- (d) The new policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of District or federal law.

Subsection 2207.14 is renumbered subsection 2207.15 and is amended to read as follows:

2207.15 The following standards for Basic (Core) Benefits common to benefit plans A through J shall apply:

- (a) Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured:
  - (1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
  - (2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
  - (3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other

appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days; provided that the provider shall accept the issuer’s payment as payment in full and may not bill the insured for any balance;.

- (4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
- (5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

- (b) An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic “core” package of benefits, but not in lieu of the basic “core” package of Benefits.

Subsections 2207.15 and 2207.16 are renumbered subsections 2207.16 and 2207.17, respectively.

A new section 2207a is added to read as follows:

**2207a BENEFIT STANDARDS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY ON OR AFTER JUNE 1, 2010**

2207a-1 The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in the District on or after June 1, 2010.

2207a-2 No policy or certificate may be advertised, solicited, delivered, or issued for delivery in the District as a Medicare supplement policy or certificate unless it complies with the benefit standards in this section.

2207a-3 No issuer may offer any 1990 standardized plan for sale on or after June 1, 2010.

2207a-4 Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of section 2207.

2207a-5 The following general standards in subsection 2207a-6 through 2207a-23 apply to Medicare supplement policies and certificates and are in addition to all other requirements of this chapter.

- 2207a-6 A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition.
- 2207a-7 A Medicare supplement policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.
- 2207a-8 A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
- 2207a-9 A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.
- 2207a-10 No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.
- 2207a-11 Each Medicare supplement policy shall be guaranteed renewable.
- 2207a-12 No Medicare supplement policy shall be canceled or non-renewed by the issuer solely on the ground of health status of the individual.
- 2207a-13 No Medicare supplement policy shall be canceled or non-renewed by the issuer for any reason other than nonpayment of premium or material misrepresentation.
- 2207a-14 If the Medicare supplement policy is terminated by the group policyholder and is not replaced under subsection 2207a-16 of this chapter, the issuer shall offer certificate holders an individual Medicare supplement policy which, at the option of the certificate holder:
- (a) Provides for continuation of the benefits contained in the group policy; or
  - (b) Provides for benefits that otherwise meet the requirements of this subsection.
- 2207a-15 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 the conversion opportunity described in subsection 2207a-14; or

- (b) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

- 2207a-16 If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy that is being replaced.
- 2207a-17 Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining continuous loss.
- 2207a-18 A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.
- 2207a-19 If suspension of benefits and premiums under a Medicare supplement policy or certificate occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss or entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.
- 2207a-20 Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulations) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act).
- 2207a-21 If suspension of benefits and premiums under a Medicare supplement policy or certificate occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of

the date of loss coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of loss.

- 2207a-22 Reinstitution of coverages as described in subsections 2207a-19, 2207a-20 and 2207a-21 shall not provide for any waiting period with respect to treatment and preexisting conditions.
- 2207a-23 Reinstitution of coverages as described in subsections 2207a-19, 2207a-20 and 2207a-21 shall:
- (a) Provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and
  - (b) 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.
- 2207a-24 The following standards for Basic (“Core”) Benefits common to Medicare Supplement Insurance Plans A, B, C, D, F, F with High Deductible, G, M, and N shall apply.
- (a) Every issuer of a Medicare Supplement Insurance Benefits Plan shall make available a policy or certificate including only the following basic “core” package of benefits to each prospective insured:
    - (1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the sixty-first (61<sup>st</sup>) day through the ninetieth (90<sup>th</sup>) day in any Medicare benefit period;
    - (2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
    - (3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days; provided that the provider shall accept the issuers payment as payment in full and may not bill the insured for any balance;
    - (4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed

red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

- (5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;
- (6) Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

- (b) An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic “core” package of benefits, but not in lieu of the basic “core” package of benefits.

2207a-25

The following additional benefits shall be included in Medicare Supplement Benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by section 2208a of this chapter.

- (a) Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient deductible amount per benefit period.
- (b) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period.
- (c) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first (21<sup>st</sup>) day through the one hundredth (100<sup>th</sup>) day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.
- (d) Medicare Part B Deductible: Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.
- (e) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program of District law, and the Medicare-approved Part B charge.
- (f) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign

country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

A new section 2208a is added as follows:

**2208a            STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2010  
STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN  
POLICIES OR CERTIFICATES ISSUED FOR DELIVERY ON OR  
AFTER JUNE 1, 2010**

2208a-1            The following standards in subsection 2208a-2 through 2208a-8 are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in the District on or after June 1, 2010.

2208a-2            No policy or certificate may be advertised, solicited, delivered or issued for delivery in the District as a Medicare supplement policy or certificate unless it complies with the benefits standards in this section.

2208a-3            Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of section 2208 of this chapter.

2208a-4            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 defined in subsection 2207a-24 of this chapter.

2208a-5            If an issuer makes any of the additional benefits described in subsection 2207a-25 or offers standardized benefit Plans K or L (as described in subparagraphs 2208a-9(h) and (i)), then 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 described in subsection 2208a-4 above, a policy form or certificate form containing either standardized benefit Plan C (as described in subparagraph 2008a-9(c) of this chapter) or standard benefit Plan F (as described in subparagraph 2008a-9(e)).

2208a-6            No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in the District, except as may be permitted in subsection 2208a-10.

2208a-7            Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit plans listed in this subsection and conform to the definition in

section 2299 of this chapter. Each benefit shall be structured in accordance with the format provided in subsections 2207a-24 and 2207a-25; or, in the case of plans K or L, in subparagraphs 2208a-9(h) or (i) and list the benefits in the order shown. For purposes of this subsection, “structure, language, and format” means style, arrangement and overall content of a benefit.

- 2208a-8 In addition to the benefit plan designations required in subsection 2208a-7, an issuer may use other designations to the extent permitted by law.
- 2208a-9 The composition of 2010 Standard Benefit Plans shall be as follows:
- (a) Standardized Medicare supplement benefit plan A shall include only the basic (core) benefits as defined in subsection 2207a-24.
  - (b) Standardized Medicare supplement benefit plan B shall include only the following:
    - (1) The basic (core) benefit as defined in subsection 2207a-24 of this chapter; and
    - (2) One hundred percent (100%) of the Medicare Part A deductible as defined in subparagraph 2207a-25(a) of this chapter.
  - (c) Standardized Medicare supplement benefit plan C shall include only the following:
    - (1) The basic (core) benefit as defined in subsection 2207a-24 of this chapter; plus
    - (2) One hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in subparagraphs 2207a-25 (a), (c), (d), and (f), of this chapter, respectively.
  - (d) Standardized Medicare supplement benefit plan D shall include the following:
    - (1) The basic (core) benefit (as defined in the subsection 2207a-24 of this chapter); and
    - (2) One hundred percent (100%) of the Medicare Part A deductible, Skilled Nursing Facility Care, and Medically Necessary Emergency Care in a foreign country as defined in subparagraphs 2207a-25 (a), (c), and (f) of this chapter.

- (e) Standardized Medicare supplement plan F shall include only the following:
  - (1) The basic (core) benefit as defined in subsection 2207a-24 of this chapter; and
  - (2) One hundred percent (100%) of the Medicare part A deductible, the Skilled Nursing Facility Care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and Medically Necessary Emergency Care in a foreign country as defined in subparagraphs 2207a-25(a), (c), (d), (e), and (f) of this chapter.
  
- (f) Standardized Medicare supplement plan F with High Deductible shall include only the following:
  - (1) One hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in subparagraph (3);
  - (2) The basic (core) benefit as defined in subsection 2207a-24 and:
    - (A) One hundred percent (100%) of the Medicare Part A deductible, Skilled Nursing Facility Care;
    - (B) One hundred percent (100%) of the Medicare part “B” deductible;
    - (C) One hundred percent (100%) of the Medicare Part “B” excess charges; and
    - (D) Medically necessary emergency care in a foreign country as defined in subparagraphs 2207a-25(a), (c), (d), (e) and (f) of this chapter, respectively.
  - (3) The annual deductible in plan F with High Deductible shall consist of out-of-pocket expense, other than premiums, for services covered by [regular] plan F and shall be in addition to other specific benefit deductibles. The basis for the deductible shall be \$1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10).
  
- (g) Standardized Medicare supplement benefit plan G shall include only the following:

- (1) The basic (core) benefit as described in 2207a-24 of this chapter; and
  - (2) One hundred percent (100%) of the Medicare Part A deductible, Skilled Nursing Facility Care, one hundred percent (100%) of the Medicare Part B excess charges, and Medically Necessary Emergency Care in a foreign country as defined in subparagraphs 2207a-25(a),(c), (e), and (f), respectively.
- (h) Standardized Medicare supplement plan “K” is mandated by the Medicare Prescription Drug Improvement and Modernization Act of 2003, and shall have the following:
- (1) Part A Hospital Coinsurance 61st through 90th days: Coverage of one hundred percent (100%) of the Part A coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;
  - (2) Part A Hospital Coinsurance 91st through 150th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through 150th day in any Medicare benefit period;
  - (3) Part A Hospitalization After 150 days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer’s payment as payment in full and may not bill the insured for any balance;
  - (4) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph 10;
  - (5) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21<sup>st</sup> day through the 100<sup>th</sup> day in a Medicare benefit period for Post-hospital Skilled Nursing Facility Care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph 10;

- (6) Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and Respite Care until the out-of-pocket limitation is met as described in subparagraph 10;
  - (7) Blood: Coverage for fifty percent (50%) , under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph 10;
  - (8) Part B Cost Sharing: Except for coverage provided in subparagraph 9, coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph 10;
  - (9) Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and
  - (10) Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation of annual expenditures under Medicare Parts A and B of \$4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.
- (i) Standardized Medicare supplement plan L is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:
    - (1) The benefits described in subparagraphs 2208a-h(1), (2), (3), and (9);
    - (2) The benefit described in subparagraphs 2208a-h(4), (5), (6), (7), and (8), but substituting seventy-five percent (75%) for fifty percent (50%); and
    - (3) The benefit described in subparagraph 2208a-h(10), but substituting \$2000 for \$4000.
  - (j) Standardized Medicare supplement plan M shall include only the following:

- (1) The basic (core) benefit as defined in subsection 2207a-14; and
  - (2) Fifty percent (50%) of the Medicare Part A deductible, Skilled Nursing Facility Care; and Medically Necessary Emergency Care in a foreign country as defined in subparagraphs 2207a-25(b), (c), and (f), respectively.
- (k) Standardized Medicare supplement plan N shall include only the following:
- (1) The basic (core) benefit as defined in subsection 2207a-14 of this chapter; and
  - (2) One hundred percent (100%) of the Medicare Part A deductible, Skilled Nursing Facility Care, and Medically Necessary Emergency Care in a Foreign Country as defined in subparagraphs 2207a-15(a), (c), and (f) of this chapter, respectively, with co-payments in the following amounts:
    - (A) The lesser of twenty dollars (\$20) or the Medicare part B coinsurance or co-payment for each covered health care provider office visit (including visits to medical specialists); and
    - (B) The lesser of fifty dollars (\$50) or the Medicare part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare part A expense.

2208a-10 New or Innovative Benefits: An issuer may, with the prior approval of the Commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards subject to the following conditions:

- (a) The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective.
- (b) Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification;
- (c) New or innovative benefits shall not include an outpatient prescription drug benefit; and

- (d) New or innovative benefits shall not be used to change or reduce benefits, including change of any cost-sharing provision, in any standardized plan.

Subsection 2220.9 is amended to read as follows: The following items shall be included in the outline of coverage in the order prescribed below:

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available in the District of Columbia. Plans E, H, I, and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]

**Basic Benefits:**

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

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER			
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$[4620]; paid at 100% after limit reached	Out-of-pocket limit \$[2310]; paid at 100% after limit reached		

\*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2000 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.

**PREMIUM INFORMATION** [Boldface Type]

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

**DISCLOSURES** [Boldface Type]

Use this outline to compare benefits and premiums among policies.

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

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

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

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

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

**POLICY REPLACEMENT** [Boldface Type]

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

**NOTICE** [Boldface Type]

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

[for agents:]

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

[for direct response:]

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

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

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

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

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

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to section 2208a-8 of this regulation.]

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

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**PLAN A**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after: —While using 60 lifetime reserve days</p> <p>—Once lifetime reserve days are used:</p> <p>—Additional 365 days</p> <p>—Beyond the additional 365 days</p>	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare eligible expenses</p> <p>\$0</p>	<p>\$1068(Part A deductible)</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21<sup>st</sup> thru 100th day</p> <p>101<sup>st</sup> day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>All costs</p>

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

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

**PLAN A**

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

\* Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES—</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

## PARTS A &amp; B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN B**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1068	\$1068(Part A deductible)	\$0
61 <sup>st</sup> thru 90th day	All but \$267 a day	\$267 a day	\$0
91 <sup>st</sup> day and after: —While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
—Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0**
—Additional 365 days	\$0	\$0	All costs
—Beyond the additional 365 days			
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$133.50 a day	\$0	Up to \$133.50 a day
101st day and after	\$0	\$0	All costs

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

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

**PLAN B**

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

\* Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES—</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, F First \$135 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$135 (Part B deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints  Next \$135 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$135 (Part B deductible)  \$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE                      MEDICARE APPROVED                      SERVICES</b> Medically necessary skilled care services and medical supplies  Durable medical equipment	100%	\$0	\$0
First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN C**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61<sup>st</sup> thru 90th day</p> <p>91<sup>st</sup> day and after: —While using 60 lifetime reserve days</p> <p>—Once lifetime reserve days are used:</p> <p>Additional 365 days —Beyond the additional 365 days</p>	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1068(Part A deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare eligible expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days</p> <p>21<sup>st</sup> thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>

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

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

PLAN C

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

\* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES—</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare  Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$135 (Part B deductible)  Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints  Next \$135 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  \$0  80%	All costs  \$135 (Part B deductible)  20%	\$0  \$0  \$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$135 of Medicare Approved Amounts*	\$0	\$135(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
<b>FOREIGN TRAVEL NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maxi-mum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**PLAN D**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after: —While using 60 lifetime reserve days</p> <p>—Once lifetime reserve days are used:</p> <p>Additional 365 days —Beyond the additional 365 days</p>	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1068 (Part A deductible)</p> <p>\$267 a day</p> <p>\$534 a day \$0</p> <p>100% of Medicare eligible expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21<sup>st</sup> thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>

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

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

**PLAN D**

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

\* Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES—</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN D**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies  Durable medical equipment	100%	\$0	\$0
First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

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

**PLAN F or HIGH DEDUCTIBLE PLAN F**

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

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

**\*\*This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2000 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2000 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE,** YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1068	\$1068 (Part A deductible)	\$0
61st thru 90 <sup>th</sup> day	All but \$267 a day	\$267 a day	\$0
91st day and after: —While using 60 Lifetime reserve days	All but \$534 a day	\$534 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

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2000 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE,** YOU PAY
<p><b>SKILLED NURSING FACILITY CARE*</b>                      You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101<sup>st</sup> day and after</p>	<p>All approved amounts</p> <p>All but \$[133.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p><b>BLOOD</b>                      First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p><b>HOSPICE CARE</b>                      You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care</p>	<p>Medicare co-payment/coinsurance</p>	<p>\$0</p>

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

**PLAN F or HIGH DEDUCTIBLE PLAN F**

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

\*Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**\*\*This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2000 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2000 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE,** YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician’s Services, inpatient and Outpatient medical and Surgical services and Supplies, physical and Speech therapy, Diagnostic tests, Durable medical Equipment, First \$135 of Medicare Approved amounts*  Remainder of Medicare Approved amounts	\$0  Generally 80%	\$135 (Part B deductible)  Generally 20%	\$0  \$0
<b>Part B excess charges</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints  Next \$135 of Medicare Approved amounts*  Remainder of Medicare Approved amounts	\$0  \$0  80%	All costs  \$135 (Part B deductible)  20%	\$0  \$0  \$0

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2000 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE, ** YOU PAY
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PLAN F or HIGH DEDUCTIBLE PLAN F**

**PARTS A & B**

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2000 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE, ** YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies —Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare — Approved Amounts	100%     \$0   80%	\$0     \$135 (Part B deductible)   20%	\$0     \$0   \$0

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>AFTER YOU PAY \$2000 DEDUCTIBLE,** PLAN PAYS</b>	<b>IN ADDITION TO \$2000 DEDUCTIBLE,** YOU PAY</b>
<p><b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>                      Medically necessary                      Emergency care services                      Beginning during the first 60 days of each trip outside the USA                      First \$250 each calendar year</p> <p>Remainder of charges</p>	<p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250</p> <p>20% and amounts over the \$50,000 lifetime maximum</p>

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**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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1068	\$1068 (Part A deductible)	\$0
61st thru 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
—Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0**
—Additional 365 days	\$0	\$0	All costs
—Beyond the additional 365 days			
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

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

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

**PLAN G**

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

\* Once you have been billed \$133.50 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$135 (Part B deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints  Next \$135 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$135 (Part B deductible)  \$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN G**

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies  —Durable medical equipment	100%	\$0	\$0
First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

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

**PLAN K**

\* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[4620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare co-payment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOSPITALIZATION**</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1068	\$534(50% of Part A deductible)	\$534(50% of Part A deductible)♦
61 <sup>st</sup> thru 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$534 a day	\$534 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

\*\*\* **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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<p><b>SKILLED NURSING FACILITY CARE**</b>                      You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility                      Within 30 days after leaving the hospital                      First 20 days</p> <p>21<sup>st</sup> thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts.</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$66.75 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$66.75 a day ♦</p> <p>All costs</p>
<p><b>BLOOD</b>                      First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>50%</p> <p>\$0</p>	<p>50% ♦</p> <p>\$0</p>
<p><b>HOSPICE CARE</b>                      You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care</p>	<p>50% of co-payment/coinsurance</p>	<p>50% of Medicare co-payment/coinsurance ♦</p>

**PLAN K**

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

\*\*\*\* Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>MEDICAL EXPENSES—</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts****	\$0	\$0	\$135 (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% ♦
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$4620)*
<b>BLOOD</b> First 3 pints	\$0	50%	50% ♦
Next \$135 of Medicare Approved Amounts****	\$0	\$0	\$135 (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$4620 per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

## PLAN K

## PARTS A &amp; B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$135 of Medicare Approved Amounts*****	\$0	\$0	\$135 (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	10%	10%♦

\*\*\*\*\*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*. <http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf>

**PLAN L**

\* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2310 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOSPITALIZATION**</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1068	\$808.50 (75% of Part A deductible)	[\$267] (25% of Part A deductible)♦
61st thru 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
—Once lifetime reserve days are used: —Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
—Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE**</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility Within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100th day	All but \$133.50 a day	Up to \$100.13 a day	Up to \$33.38 a day♦
101st day and after	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<p><b>BLOOD</b> First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>75%</p> <p>\$0</p>	<p>25% ♦</p> <p>\$0</p>
<p><b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care</p>	<p>75% of co-payment/coinsurance</p>	<p>25% of co-payment/coinsurance ♦</p>

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

**PLAN L**

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

\*\*\*\* Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>MEDICAL EXPENSES—</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physi- cian’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts****	\$0	\$0	\$135 (Part B deductible)**** ♦
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% ♦
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$2310)*
<b>BLOOD</b> First 3 pints	\$0	75%	25% ♦
Next \$135 of Medicare Approved Amounts****	\$0	\$0	\$135 (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$2310 per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**PLAN L**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$135 of Medicare Approved Amounts*****	\$0	\$0	\$135 (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	15%	5% ♦

\*\*\*\*\*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*. <http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf>

PLAN M

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1068	\$534(50% of Part A deductible)	[\$534](50% of Part A deductible)
61 <sup>st</sup> thru 90th day	All but \$267 a day	\$267 a day	\$0
91 <sup>st</sup> day and after: —While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
—Once lifetime reserve days are used: —Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>HOSPICE CARE</b>                      You must meet Medicare’s requirements, including a doctor’s certification of terminal illness</p>	<p>All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare co-payment/ coinsurance</p>	<p>\$0</p>

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

**PLAN M**

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

\* Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES—</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment —First \$135 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$135 (Part B deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints  Next \$135 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$135 (Part B deductible)  \$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment	\$0	\$0	\$135(Part B deductible)
First \$135 of Medicare Approved Amounts*			
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

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

**PLAN N**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61<sup>st</sup> thru 90th day</p> <p>91<sup>st</sup> day and after: —While using 60 lifetime reserve days</p> <p>—Once lifetime reserve days are used: —Additional 365 days</p> <p>—Beyond the additional 365 days</p>	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1068(Part A deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare eligible expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21<sup>st</sup> thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p><b>BLOOD</b> First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>HOSPICE CARE</b>                      You must meet Medicare’s requirements, including a doctor’s certification of terminal illness</p>	<p>All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare co-payment/coinsurance</p>	<p>\$0</p>

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

PLAN N

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

\* Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>MEDICAL EXPENSES—</b>                      IN OR OUT OF THE                      HOSPITAL AND                      OUTPATIENT HOSPITAL                      TREATMENT, such as                      physician’s services, inpatient                      and outpatient medical and                      surgical services and supplies,                      physical and speech therapy,                      diagnostic tests, durable                      medical equipment                      First \$135 of Medicare                      Approved Amounts*</p>	\$0	\$0	\$135 (Part B deductible)
<p>Remainder of Medicare                      Approved Amounts</p>	Generally 80%	Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The co- payment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	up to \$20 per office visit and up to \$50 per emergency room visit. The co-payment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
<p><b>Part B Excess Charges</b>                      (Above Medicare                      Approved Amounts)</p>	\$0	\$0	All costs
<p><b>BLOOD</b>                      First 3 pints</p>	\$0	All costs	\$0
<p>Next \$135 of Medicare                      Approved Amounts*</p>	\$0	\$0	\$135 (Part B deductible)
<p>Remainder of Medicare                      Approved Amounts</p>	80%	20%	\$0
<p><b>CLINICAL LABORATORY                      SERVICES—TESTS FOR                      DIAGNOSTIC SERVICES</b></p>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies  —Durable medical equipment	100%	\$0	\$0
First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

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

Section 2228 is renumbered section 2229 and a new section 2228 is added to read as follows:

**2228 PROHIBITION AGAINST USE OF GENETIC INFORMATION AND REQUESTS FOR GENETIC TESTING**

2228.1 This section applies to all policies with policy years beginning on or after May 21, 2009.

2228.2 An issuer of a Medicare supplement policy or certificate shall not:

- (a) Deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; or
- (b) Discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

2228.3 Nothing in subsection 2228.2 shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from doing the following:

- (a) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or
- (b) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual shall not be used as genetic information about other group members or to further increase the premium for the group).

2228.4 An issuer of a Medicare supplement policy or certificate shall not request or require an individual or family member of such individual to undergo a genetic test.

2228.5 Subsection 2228.4 shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and section 264 of the Health Insurance Portability Accountability Act of 1996, as may be revised from time to time) and consistent with subsection 2228.2.

2228.6 For purposes of carrying out subsection 2228.5, an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

- 2228.7 Notwithstanding subsection 2228.4, an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual, undergo a genetic test if each of the following conditions is met:
- (a) The request is made pursuant to research that complies with part 46 of title 45 of the Code of Federal Regulations, or equivalent federal regulations, and any applicable District of local law or regulations for the protection of human subjects in research;
  - (b) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:
    - (1) Compliance with the request is voluntary; and
    - (2) Non-compliance will have no effect on enrollment status or premium or contribution amounts.
  - (c) No genetic information collected or acquired under this subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate;
  - (d) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted; and
  - (e) The issuer complies with such other conditions as the Secretary may by rule or regulation require for activities conducted under this subsection.
- 2228.8 An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.
- 2228.9 An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.
- 2228.10 If an insurer of a Medicare supplement policy or certificate obtains genetic information incidental to requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of subsection 2228.9 if such request, requirement, or purchase is not in violation of subsection 2228.8.
- 2228.11 For the purposes of this section only, the following words and phrases shall have the meaning ascribed:

- (a) “Issuer of a Medicare supplement policy or certificate” includes third-party administrator, or other person acting for or on behalf of such issuer.
- (b) “Family member” means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.
- (c) “Genetic information” means, with respect to any individual, information about an individual’s genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term “genetic information” does not include information about the sex or age of any individual.
- (d) “Genetic Services” means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.
- (e) “Genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term “genetic test” does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.
- (f) “Underwriting purpose” means as follows:
  - (1) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;
  - (2) The computation of premium or contribution amounts under the policy;
  - (3) The application of any pre-existing condition exclusion under the policy; and

- (4) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

**2229 SEPARABILITY**

2229.1 If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 2299 is amended to add the following definitions:

“Pre-Standardized Medicare supplement benefit plan,” “Pre-Standardized benefit plan,” or “Pre-Standardized plan” means a group or individual policy of Medicare supplement insurance issued prior to May 1, 1999.

“1990 Standardized Medicare supplement benefit plan,” “1990 Standardized benefit plan,” or “1990 plan” means a group or individual policy of Medicare supplement insurance issued on or after May 1, 1999 and prior to June 1, 2010 and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

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

Persons desiring to comment on these proposed rules should submit comments in writing to Mr. Philip Barlow, Associate Commissioner for Insurance, Department of Insurance, Securities and Banking, 810 First Street, N.E., Suite 701, Washington, D.C. 20002. Comments must be received not later than thirty (30) days after the date of publication of this notice in the *D.C. Register*.

Copies of the proposed rules may be obtained from the Department at the address stated above.

APPENDIX A

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

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

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

Medicare Supplement Credibility Table

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

- 1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
- 2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
- 3 Includes Modal Loadings and Fees Charged.
- 4 Excludes Active Life Reserves.
- 5 This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet, for Calculation of Benchmark Ratios".

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

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

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

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

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

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

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

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

<sup>1</sup> Individual, Group, Individual Medicare Select, or Group Medicare Select Only.  
<sup>2</sup> "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

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

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

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

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

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

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

<sup>3</sup> Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

<sup>4</sup> For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

<sup>5</sup> These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

<sup>6</sup> To include the earned premium for all years prior to as well as the 15<sup>th</sup> year prior to the current year.

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

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

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

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

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

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

<sup>3</sup> Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

<sup>4</sup> For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

<sup>5</sup> These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

<sup>6</sup> To include the earned premium for all years prior to as well as the 15<sup>th</sup> year prior to the current year.

APPENDIX B

FORM FOR REPORTING  
MEDICARE SUPPLEMENT POLICIES

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

Due March 1, annually

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

Policy and Certificate #	Date of Issuance

\_\_\_\_\_  
Signature

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

\_\_\_\_\_  
Date

## APPENDIX C

## DISCLOSURE STATEMENTS

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

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

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

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

**This is not Medicare Supplement Insurance**

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

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

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

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

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

- hospitalization
- physician services
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

**Before You Buy This Insurance**

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

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

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

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

**This is not Medicare Supplement Insurance**

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

**This insurance duplicates Medicare benefits when:**

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

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

- hospitalization
- physician services
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

**Before You Buy This Insurance**

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

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

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

<p style="text-align: center;"><b>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</b></p>
--

**This is not Medicare Supplement Insurance**

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

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

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

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

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

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

<p style="text-align: center;"><b>Before You Buy This Insurance</b></p>
---

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

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

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

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

**This is not Medicare Supplement Insurance**

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

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

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

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

**Before You Buy This Insurance**

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

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

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

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

**This is not Medicare Supplement Insurance**

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

**This insurance duplicates Medicare benefits when:**

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

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

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

- hospitalization
- physician services
- outpatient prescription drugs if you are enrolled in Medicare Part D
- hospice
- other approved items and services

**Before You Buy This Insurance**

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

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

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

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

**This is not Medicare Supplement Insurance**

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

**This insurance duplicates Medicare benefits when:**

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

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

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

- hospitalization
- physician services
- hospice care
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items & services

**Before You Buy This Insurance**

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

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

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

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

**This is not Medicare Supplement Insurance**

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

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

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

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

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

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

**Before You Buy This Insurance**

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

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

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

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

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

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

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

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

- hospitalization
- physician services
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

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

**Before You Buy This Insurance**

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

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

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

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

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

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

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

- hospitalization
- physician services
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

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

**Before You Buy This Insurance**

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

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

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

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

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

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

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

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

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

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

**Before You Buy This Insurance**

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

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

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

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

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

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

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

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

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

**Before You Buy This Insurance**

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

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

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

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

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

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

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

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

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

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

**Before You Buy This Insurance**

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

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

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

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

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

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

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

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

- hospitalization
- physician services
- hospice care
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items & services

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

**Before You Buy This Insurance**

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

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

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

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

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

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

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

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

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

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

**Before You Buy This Insurance**

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

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