

BEFORE THE STATE AUDITOR AND COMMISSIONER OF INSURANCE
OF THE STATE OF MONTANA

In the matter of the proposed)	NOTICE OF PUBLIC HEARING ON
amendment of ARM 6.6.504,)	PROPOSED AMENDMENT AND
6.6.506, 6.6.507, 6.6.507A,)	ADOPTION
6.6.507B, 6.6.507C, 6.6.508,)	
6.6.508A, 6.6.509, and 6.6.511, and)	
the adoption of New Rules I, II, III,)	
and IV pertaining to Medicare)	
Supplements)	

TO: All Concerned Persons

1. On June 4, 2009, at 10:00 a.m., the State Auditor and Commissioner of Insurance will hold a public hearing in the 2nd floor conference room of the State Auditor's Office, 840 Helena Ave., Helena, Montana, to consider the proposed amendment of the above-stated rules.

2. The State Auditor and Commissioner of Insurance will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the department no later than 5:00 p.m., May 27, 2009, to advise us of the nature of the accommodation that you need. Please contact Darla Sautter, State Auditor's Office, 840 Helena Avenue, Helena, Montana, 59601; telephone (406) 444-2726; TDD (406) 444-3246; fax (406) 444-3497; or e-mail dsautter@mt.gov.

3. The rules as proposed to be amended provide as follows, stricken matter interlined, new matter underlined:

6.6.504 DEFINITIONS For purposes of this subchapter, the terms defined in 33-22-903, MCA, will have the same meaning in this subchapter unless clearly designated otherwise. The following definitions are in addition to those in 33-22-903, MCA.

(1) through (6)(b) remain the same.

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

(a) Medicare supplement health insurance as defined under section 1882(g)(1) of the Social Security Act;

(b) coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and

(c) similar supplemental coverage provided to coverage under a group health plan.

(7) through (9) remain the same, but are renumbered (8) through (10).

~~(40)~~ (11) "Medicare supplement policy" has the meaning provided for in 33-22-903, MCA, except that "Medicare supplement policy" does not include Medicare advantage plans established under Medicare Part C, outpatient prescription drug plans established under Medicare Part D, or any health care prepayment plan

(HCPP) that provides benefits pursuant to an agreement under section 1833(a)(1)(A) of the Social Security Act. Policies that are advertised, marketed or designed primarily to cover out-of-pocket costs under Medicare advantage plans (established under Medicare Part C) must comply with the Medicare supplement requirements contained in Montana administrative rule and statute.

(12) "Pre-standardized Medicare Supplement Benefit Plan," "pre-standardized benefit plan," or "pre-standardized plan" means a group or individual policy of Medicare supplement insurance issued prior to July 16, 1993.

(13) "1990 standardized Medicare Supplement Benefit Plan," "1990 standardized benefit plan," or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after July 16, 1993, 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.

(14) "2010 standardized Medicare Supplement Benefit Plan," "2010 standardized benefit plan," or "2010 plan" means a group or individual policy of Medicare supplement insurance issued on or after June 1, 2010.

(11) remains the same, but is renumbered (15).

AUTH: 33-1-313, 33-22-904, MCA

IMP: 33-22-902, 33-22-903, 33-22-923, MCA

REASON: It is necessary to amend this rule to reflect changes in the Federal regulations that were adopted in the NAIC Medicare Supplement Model Regulation. Federal law requires the states to adopt these rule changes by September 2009. New plan types will be effective June 1, 2010, and are described in these proposed rule changes, so additional definitions are necessary.

6.6.506 PROHIBITED POLICY PROVISIONS (1) Except for permitted preexisting condition clauses as described in ARM 6.6.510, ~~and 6.6.522,~~ and [NEW RULE I](1)(a)(i), no policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(2) through (4)(c)(ii) remain the same.

AUTH: 33-1-313, 33-22-904, 33-22-905, MCA

IMP: 33-15-303, 33-22-902, 33-22-904, 33-22-905, MCA

REASON: It is necessary to amend this rule to reference the preexisting condition limitations contained in the [New Rule I] pertaining to policies or certificates issued after June 2010.

6.6.507 MINIMUM BENEFIT STANDARDS FOR MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED OR DELIVERED PRIOR TO JUNE 1, 2010 (1) The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state prior

to June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(a) the following standards are in addition to all other requirements of this rule subchapter and Title 33, chapter 22, part 9, MCA, Medicare Supplement Insurance Minimum Standards:

(i) and (ii) remain the same.

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

(iv) through (1)(vi)(A) remain the same.

(B) provides for such benefits as ~~otherwise meets the requirements of this subsection~~ are required to meet the minimum standards as defined in [NEW RULE I(4)];

(vii) through (3)(c) remain the same.

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

(ii) and (iii) remain the same.

(4) If an issuer makes a written offer to the Medicare supplement policyholders or certificateholders of one or more of its plans, to exchange during a specified period from his or her pre-standardized plan or 1990 standardized plan to a 2010 standardized plan as described in [NEW RULE II], 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 pre-standardized plan or a 1990 standardized policy or certificate with an issue age rate 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 for approval as part of the rate filing;

(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 preexisting condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged pre-standardized plan or 1990 standardized policy or certificate of the insured, but may apply preexisting condition limitations of no more than six months to any added benefits contained in the new 2010 standardized policy or certificate not contained in the exchanged policy; and

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

~~(4)~~(5) Standards for basic ("core") benefits common to benefit plans A through ~~L~~ J include the following:

(a) through (4)(c)(ii)(C) remain the same.

AUTH: 33-1-313, 33-22-904, 33-22-905, MCA

IMP: 33-15-303, 33-22-902, 33-22-904, 33-22-905, MCA

REASON: It is necessary to amend this rule to reflect changes in the Federal regulations that were adopted in the NAIC Medicare Supplement Model Regulation. Federal law requires the states to adopt these rule changes by September 2009. New plan types will be effective June 1, 2010, and are described in these proposed rule changes, so it is necessary to describe how pre 2010 plans could be converted to post 2010 plans.

6.6.507A STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 1990 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY ON OR AFTER 1990, AND PRIOR TO JUNE 1, 2010 (1) through (7) remain the same.

AUTH: 33-1-313, 33-22-904, MCA

IMP: 33-22-902, 33-22-904, 33-22-905, MCA

REASON: It is necessary to amend this rule to indicate that this rule applies only to policies and certificates issued prior to June 2010.

6.6.507B OPEN ENROLLMENT (1) No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for a policy or certificate is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both ~~who is~~ 65 years of age or older and first is enrolled for benefits under Medicare Part B, or if open enrollment was delayed due to employment past age 65. Each Medicare supplement policy or certificate currently available from an issuer must be made available to all applicants who qualify under this rule without regard to age.

(2) through (4) remain the same.

AUTH: 33-1-313, 33-22-904, 33-22-905, MCA

IMP: 33-22-902, 33-22-904, MCA

REASON: It is necessary to amend this rule to clarify that an individual who had previously enrolled in Part B (for instance an individual eligible by reason of disability) is still entitled to open enrollment when that individual turns 65 or otherwise becomes eligible for open enrollment. Therefore, the word "first" is deleted. This change is consistent with the Federal regulations. It is also necessary to clarify that individuals who are actively at work past the age of 65, are still entitled to open enrollment period when they retire and leave the group health plan.

6.6.507C GUARANTEED ISSUE FOR ELIGIBLE PERSONS (1) through (1)(b) remain the same.

(i) deny or condition the ~~insurance~~ issuance or effectiveness of a Medicare supplement policy described in ~~(3)~~ (5) that is offered and is available for issuance to new enrollees by the issuer;

(ii) through (5) remain the same.

(a) an eligible person defined in (2)(a), (b), (c), or (d) is entitled to the issuance of a Medicare supplement policy ~~with any level of benefits up to the level of the previous policy without underwriting offered by any issuer. If such an eligible person chooses a Medicare supplement policy with a higher level of benefits than the previous policy, the issuer may underwrite the new policy; which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L offered by any issuer;~~

(b) through (5)(d) remain the same.

(e) An eligible person defined in (2)(g) is entitled to the issuance of a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued ~~to the~~ the individual's Medicare supplement policy with outpatient prescription drug coverage. However, if the eligible person wishes to enroll in an A, B, C, F (including high deductible F), K, or L and that issuer does not offer that plan, then the eligible person is entitled to have that plan issued by any issuer who makes it available for sale to new enrollees in Montana.

(6) through (6)(b) remain the same.

AUTH: 33-1-313, 33-22-904, 33-22-905, MCA

IMP: 33-22-902, 33-22-904, 33-22-905, MCA

REASON: It is necessary to amend this rule to correct typographical errors and to reflect exact changes in the Federal regulations that occurred in 2005. This rule reflects the exact plan types available to eligible individuals.

6.6.508 LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM (1) through (2)(a) remain the same.

(b) If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation (see ARM 6.6.524) must be done on a statewide basis for each type in a standard Medicare Supplement Benefit Plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(c) through (4) remain the same.

AUTH: 33-1-313, 33-22-904, 33-22-906, MCA

IMP: 33-15-303, 33-22-902, 33-22-906, MCA

REASON: It is necessary to amend this rule to adopt NAIC model language and provide additional detail relating to refund and credit calculations.

6.6.508A FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES (1) through (3) remain the same.

(4) Except as provided in (4)(a), an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare Supplement Benefit Plan. ~~Forms H, I, and J may be approved both with and without outpatient prescription drug coverage.~~

(a) through (7) remain the same.

AUTH: 33-1-313, 33-22-904, 33-22-905, 33-22-906, MCA

IMP: 33-22-904, 33-22-906, MCA

REASON: It is necessary to amend this rule to reflect changes in the Federal regulations that were adopted in the NAIC Medicare Supplement Model Regulation. Federal law requires the states to adopt these rule changes by September 2009. Effective June 1, 2010, Forms H, I, and J will no longer be approved as new filings, and since 2005 those forms could not be approved with prescription drug benefits in them because of the availability of Part D coverage.

6.6.509 REQUIRED DISCLOSURE PROVISIONS (1) through (9)(a) remain the same.

(b) The outline of coverage provided to applicants consists of a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage must be in the language and format prescribed below in no less than 12 point type. All plans ~~A-L~~ must be shown on the cover page, and the plans that are offered by the issuer must be prominently identified. Premium information for plans that are offered must be shown on the cover page or immediately following the cover page and must be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant must be illustrated.

(c) The following items must be included in the outline of coverage in the order prescribed below:

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page: 1 of 2

Benefit Plan(s)____[insert letter(s) of plan(s) being offered]

These charts show the benefits included in each of the 1990 standardized Medicare supplement plans. Every company must make available Plan A. Some plans may not be available in your state. New 1990 standardized benefit plans may not be issued after June 1, 2010.

See Outline of Coverage sections for details about ALL plans

Basic Benefits for Plans A-J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), copayments for hospital outpatient services.

Blood: First three pints of blood each year.

A	B	C	D	E
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		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 B Deductible		
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery	
				Preventive Care NOT covered by Medicare

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

* Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year \$47301860 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses exceed \$47301860. 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.

[COMPANY NAME]

Outline of Medicare Supplement Coverage - Cover Page 2

Basic Benefits for Plans K and L: include similar services as Plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
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Basic Benefits	100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 50% hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B coinsurance, except 100% coinsurance for Part B preventive services	100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 75% hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B coinsurance, except 100% coinsurance for Part B preventive services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	[\$4000 4140] Out of Pocket Annual Limit***	[\$2000 2070] Out of Pocket Annual Limit***

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

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

See Outlines of Coverage for details and exceptions.

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

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

Plans E, 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 copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.

Blood: First three pints of blood each year.

Hospice: Part A coinsurance.

<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>F</u>	<u>F*</u>	<u>G</u>
<u>Basic, including 100% Part B coinsurance</u>		<u>Basic, including 100% Part B coinsurance</u>				
		<u>Skilled Nursing Facility Coinsurance</u>	<u>Skilled Nursing Facility Coinsurance</u>	<u>Skilled Nursing Facility Coinsurance</u>		<u>Skilled Nursing Facility Coinsurance</u>
	<u>Part A Deductible</u>	<u>Part A Deductible</u>	<u>Part A Deductible</u>	<u>Part A Deductible</u>		<u>Part A Deductible</u>
		<u>Part B Deductible</u>		<u>Part B Deductible</u>		
				<u>Part B Excess (100%)</u>		<u>Part B Excess (100%)</u>
		<u>Foreign Travel Emergency</u>	<u>Foreign Travel Emergency</u>	<u>Foreign Travel Emergency</u>		<u>Foreign Travel Emergency</u>

<u>K</u>	<u>L</u>	<u>M</u>	<u>N</u>
<u>Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%</u>	<u>Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%</u>	<u>Basic, including 100% Part B coinsurance</u>	<u>Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit and up to \$50 copayment for ER</u>
<u>50% Skilled Nursing Facility Coinsurance</u>	<u>75% Skilled Nursing Facility Coinsurance</u>	<u>Skilled Nursing Facility Coinsurance</u>	<u>Skilled Nursing Facility Coinsurance</u>
<u>50% Part A Deductible</u>	<u>50% Part A Deductible</u>	<u>50% Part A Deductible</u>	<u>50% Part A Deductible</u>
		<u>Foreign Travel Emergency</u>	<u>Foreign Travel Emergency</u>
<u>Out-of-pocket limit \$[4140]; paid at 100% after limit reached</u>	<u>Out-of-pocket limit \$[2070]; paid at 100% after limit reached</u>		

* Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$1860] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

(10) and (11) remain the same.

AUTH: 33-1-313, 33-22-904, 33-22-907, MCA

IMP: 33-15-303, 33-22-902, 33-22-904, 33-22-907, MCA

REASON: It is necessary to amend this rule to reflect changes in the Federal regulations that were adopted in the NAIC Medicare Supplement Model Regulation. Federal law requires the states to adopt these rule changes by September 2009. New plan types will be effective June 1, 2010, and are described in these proposed rule changes. The requirements for the 2010 plans are detailed in these new charts.

6.6.511 SAMPLE FORMS OUTLINING COVERAGE (1) The following amounts, as published in the Federal Register, for services furnished in the current calendar year under Medicare's hospital insurance program (Medicare Part A), must apply to the charts for 1990 Plans A through L for policies issued prior to June 2010 in (2)(b) through (m). In each chart, the rule cited in brackets as ARM [6.6.511(1)(a)], [6.6.511(1)(b)], [6.6.511(1)(c)], [6.6.511(1)(d)], [6.6.511(1)(e)], [6.6.511(1)(f)], [6.6.511(1)(g)], [6.6.511(1)(h)], [6.6.511(1)(i)], or [6.6.511(1)(j)], represents the dollar amount specified in the cited rule subsection. The issuer must replace each bracket and rule cite with the correct dollar amount contained in the cited rule subsection when the issuer prints the charts:

- (a) inpatient hospital deductible = ~~\$992942.00~~;
- (b) daily coinsurance amount for the 61st through 90th days of hospitalization in a benefit period = ~~\$248228.00~~;
- (c) daily coinsurance amount for lifetime reserve days = ~~\$496456.00~~;
- (d) daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = ~~\$124114.00~~;
- (e) 50% of inpatient hospital deductible = ~~\$496456.00~~;
- (f) 75% of inpatient hospital deductible = ~~\$744684.00~~;
- (g) 25% of inpatient hospital deductible = ~~\$248228.00~~;
- (h) 50% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = ~~\$6257.00~~;
- (i) 75% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = ~~\$93,085.50~~;
- and
- (j) 25% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = ~~\$31,028.50~~.

(2) remains the same.

(a) **COVER PAGE**
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 prior to June 1, 2010.

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 "The Medicare Handbook" 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 rule. An issuer may use additional benefit plan designations on these charts pursuant to ARM 6.6.507A(4).]

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

(b) PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: ---While using 60 lifetime reserve days ---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	All but \$[6.6.511(1)(a)] All but \$[6.6.511(1)(b)] a day All but \$[6.6.511(1)(c)] a day \$0 \$0	\$0 \$[6.6.511(b)] a day \$[6.6.511(1)(c)] a day 100% of Medicare eligible expenses \$0	\$[6.6.511(1)(a)] (Part A deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101 st day and after	All approved amounts All but \$[6.6.511(1)(d)] a day \$0	\$0 \$0 \$0	\$0 Up to \$[6.6.511(1)(d)] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited <u>copayment</u> /coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**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 \$[13100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, --First \$[13100] of Medicare approved amounts*	\$0	\$0	\$[13100] (Part B deductible)
--Remainder of Medicare approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[13100] of Medicare ---approved amounts*	\$0	\$0	\$[13100] (Part B deductible)
Remainder of Medicare ---approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment ---First \$[13100] of Medicare approved amounts*	\$0	\$0	\$[13100] (Part B deductible)
---Remainder of Medicare approved amounts	80%	20%	\$0

(c)

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[6.6.511(1)(a)]	\$[6.6.511(1)(a)] (Part A deductible)	\$0
61st thru 90th day	All but \$[6.6.511(1)(b)] a day	\$[6.6.511(1)(b)] a day	\$0
91st day and after: ---While using 60 lifetime reserve days	All but \$[6.6.511(1)(c)] a day	\$[6.6.511(1)(c)] a day	\$0
---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	\$0 \$0	100% of Medicare eligible expenses \$0	\$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[6.6.511(1)(d)] a day	\$0	Up to \$[6.6.511(1)(d)] a day
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these	All but very limited <u>copayment/</u> coinsurance for out- patient drugs and inpatient respite care	\$0	Balance

**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 \$[13100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[13100] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$[13100] (Part B deductible) \$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[13100] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[13100] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First \$[13100] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[13100] (Part B deductible) \$0

(d) 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
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<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after: ---While using 60 lifetime reserve days</p> <p>---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days</p>	<p>All but \$[6.6.511(1)(a)]</p> <p>All but \$[6.6.511(1)(b)] a day</p> <p>All but \$[6.6.511(1)(c)] a day</p> <p>\$0</p> <p>\$0</p>	<p>\$[6.6.511(1)(a)] (Part A deductible)</p> <p>\$[6.6.511(1)(b)] a day</p> <p>\$[6.6.511(1)(c)] a day</p> <p>100% of Medicare eligible expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$[6.6.511(1)(d)] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$[6.6.511(1)(d)] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0 \$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for out-patient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

**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 \$[13100] 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
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MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[13100] of Medicare approved amounts*	\$0	\$[13100] (Part B deductible)	\$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[13100] of Medicare approved amounts*	\$0	\$[13100] (Part B deductible)	\$0
Remainder of Medicare approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First \$[13100] of Medicare approved amounts*	100%	\$0	\$0
Remainder of Medicare approved amounts	80%	20%	\$0

PLAN C

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

(e) PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[6.6.511(1)(a)]	\$[6.6.511(1)(a)] (Part A deductible)	\$0
61st thru 90th day	All but \$[6.6.511(1)(a)] a day	\$[6.6.511(1)(b)] a day	\$0
91st day and after: ---While using 60 lifetime reserve days ---Once lifetime reserve days are used: ---Additional 365 days	All but \$[6.6.511(1)(c)] a day \$0	\$[6.6.511(1)(c)] a day 100% of Medicare eligible expenses	\$0 \$0**
---Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[6.6.511(1)(d)] a day	Up to \$[6.6.511(1)(d)] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**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 \$[13100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[13100] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$[13100] (Part B deductible) \$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[13100] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[13100] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$[13100] of Medicare approved amounts*	\$0	\$0	\$[13100] (Part B deductible)
Remainder of Medicare approved amounts*	80%	20%	\$0
AT-HOME RECOVERY SERVICES- NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
---Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
---Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
---Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

(f)

PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: ---While using 60 lifetime reserve days ---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 Days	All but \$[6.6.511(1)(a)]	\$[6.6.511(1)(a)] (Part A deductible)	\$0
	All but \$[6.6.511(1)(b)] a day	\$[6.6.511(1)(b)] a day	\$0
	All but \$[6.6.511(1)(c)] a day	\$[6.6.511(1)(c)] a day	\$0
	\$0	100% of Medicare eligible expenses	\$0**
	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101 st day and after	All approved amounts All but \$[6.6.511(1)(d)] a day	\$0 Up to \$[6.6.511(1)(d)] a day	\$0 \$0
	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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

PLAN E
MEDICARE (PART B) - MEDICAL SERVICES - PER BENEFIT PERIOD

*Once you have been billed \$[13100] 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
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MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[13100] of Medicare approved amounts*	\$0	\$0	\$[13100] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[13100] of Medicare approved amounts*	\$0	\$0	\$[13100] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First \$[13100] of Medicare approved amounts*	100%	\$0	\$0
Remainder of Medicare approved amounts	80%	20%	\$0
	\$0	\$0	\$[13100] (Part B deductible)

PLAN E

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

***PREVENTIVE MEDICARE CARE BENEFIT-NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First \$120 each calendar year	\$0	\$120	\$0
Additional charges	\$0	\$0	All costs

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

(g) 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 \$[186730] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[186730]. 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 \$[186730] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO \$[186730] DEDUCTIBLE, **] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[6.6.511(1)(a)]	\$[6.6.511(1)(a)] (Part A deductible)	\$0
61st thru 90th day	All but [6.6.511(1)(b)] a day	\$[6.6.511(1)(b)] a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$[6.6.511(1)(c)] a day	\$[6.6.511(1)(c)] a day	\$0
Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	\$0 \$0	100% Medicare eligible expenses \$0	\$0*** All costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[6.6.511(1)(d)] a day	Up to \$[6.6.511(1)(d)] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

***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 \$[13100] 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 \$[186730] deductible. Benefits from the high deductible Plan F will begin until out-of-pocket expenses are \$[186730]. 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 \$[186730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[186730] DEDUCTIBLE,**] YOU PAY
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MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[13100] of Medicare approved amounts*	\$0	\$[13100] (Part B deductible)	\$0
Remainder of Medicare approved Amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (Above Medicare approved amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[13100] of Medicare approved amounts*	\$0	\$[13100] (Part B deductible)	\$0
Remainder of Medicare approved amounts	80%	20%	\$0
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 \$[186730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[186730] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies	100%	\$0	\$0
---Durable medical equipment First \$[13100] of Medicare approved amounts*	\$0	\$[13100] (Part B deductible)	\$0
---Remainder of Medicare approved amounts	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[186730] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO \$[186730] DEDUCTIBLE, **] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

(h) PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	**YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[6.6.511(1)(a)]	\$[6.6.511(1)(a)] (Part A deductible)	\$0
61st thru 90th day	All but \$[6.6.511(1)(b)] a day	\$[6.6.511(1)(b)] a day	\$0
91st day and after: ---While using 60 lifetime reserve days ---Once lifetime reserve days are used: ---Additional 365 days	All but \$[6.6.511(1)(c)] a day	\$[6.6.511(1)(c)] a day	\$0
---Beyond the additional 365 days	\$0	100% Medicare eligible expenses	\$0** All costs
	\$0	\$0	

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[6.6.511(1)(d)] a day	Up to \$[6.6.511(1)(d)] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

****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 \$[13100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[13100] of Medicare approved amounts*	\$0	\$0	\$[13100] (Part B deductible)
Remainder of Medicare approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	100%	\$0

BLOOD First 3 pints	\$0	All costs	\$0
Next \$[13100] of Medicare approved amounts*	\$0	\$0	\$[13100] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies	100%	\$0	\$0
---Durable medical equipment First \$[13100] of Medicare approved amounts*	\$0	\$0	\$[13100] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES- NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan ---Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
---Number of visits covered (Must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
---Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

(i)

PLAN H

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[6.6.511(1)(a)]	\$[6.6.511(1)(a)] (Part A deductible)	\$0
61st thru 90th day	All but \$[6.6.511(1)(b)] a day	\$[6.6.511(1)(b)] a day	\$0
91st day and after: ---While using 60 lifetime reserve days	All but \$[6.6.511(1)(c)] a day	\$[6.6.511(1)(c)] a day	\$0
---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	\$0 \$0	100% of Medicare eligible expenses \$0	\$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[6.6.511(1)(d)]a day	Up to \$[6.6.511(1)(d)] a day	\$0
101st day and after	\$0	\$0	All costs

BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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

PLAN H

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

*Once you have been billed \$[13100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[13100] of Medicare approved amounts*	\$0	\$0	\$[13100] (Part B deductible)
Remainder of Medicare approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	0%	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[13100] of Medicare approved amounts*	\$0	\$0	\$[13100] (Part B deductible)
Remainder of Medicare Approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN H

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies	100%	\$0	\$0
---Durable medical equipment First \$[13100] of Medicare approved amounts*	\$0	\$0	\$[13100] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

(j)

PLAN I

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[6.6.511(1)(a)]	\$[6.6.511(1)(a)] (Part A deductible)	\$0
61st thru 90th day	All but \$[6.6.511(1)(b)] a day	\$[6.6.511(1)(b)] a day	\$0
91st day and after: ---While using 60 lifetime reserve days	All but \$[6.6.511(1)(c)] a day	\$[6.6.511(1)(c)] a day	\$0
---Once lifetime reserve days are used:			
---Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
---Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[6.6.511(1)(d)] a day	Up to \$[6.6.511(1)(d)] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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

PLAN I

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

*Once you have been billed \$[13100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[13100] of Medicare approved amounts*	\$0	\$0	\$[13100] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[13100] of Medicare approved amounts*	\$0	\$0	\$[13100] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN I

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies	100%	\$0	\$0
---Durable medical equipment First \$[13100] of Medicare approved amounts*	\$0	\$0	\$[13100] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan ---Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
---Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
---Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

(k) PLAN J or HIGH DEDUCTIBLE PLAN J

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

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

[**This high deductible plan pays the same benefits as plan J after one has paid a calendar year \$[17301860] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are \$[17301860]. 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 \$[47301860] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO \$[47301860] DEDUCTIBLE, **] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[6.6.511(1)(a)]	\$[6.6.511(1)(a)] (Part A deductible)	\$0
61st thru 90th day	All but \$[6.6.511(1)(b)] a day	\$[6.6.511(1)(b)] a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$[6.6.511(1)(c)] a day	\$[6.6.511(1)(c)] a day	\$0
Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	\$0 \$0	100% of Medicare eligible expenses \$0	\$0*** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[6.6.511(1)(d)] a day	Up to \$[6.6.511(1)(d)] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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

PLAN J or HIGH DEDUCTIBLE PLAN J

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

*Once you have been billed \$[13100] 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 as plan J after one has paid a calendar year \$[47301860] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are \$[47301860]. 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 \$[47301860] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO \$[47301860] DEDUCTIBLE, **] YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[13100] of Medicare approved amounts*	\$0	\$[13100] (Part B deductible)	\$0
Remainder of Medicare approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare approved amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0		\$0
Next \$[13100] of Medicare approved amounts*	\$0	All costs \$[13100] (Part B deductible)	\$0
Remainder of Medicare approved amounts	\$0	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[47301860] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO \$[47301860] DEDUCTIBLE, **] YOU PAY

HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$[13100] of Medicare approved amounts*	\$0	\$[13100] (Part B deductible)	\$0
Remainder of Medicare approved amounts	80%	20%	\$0
HOME HEALTH CARE AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
Number of visits covered (Must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
Calendar year maximum	\$0	\$1,600	

PLAN J or HIGH DEDUCTIBLE PLAN J
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[47301860] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[47301860] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

***PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All costs
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***Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

(I) PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[414000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[6.6.511(1)(a)]	\$[6.6.511(1)(a)] (50% of Part A deductible)	\$[6.6.511(1)(e)]♦
61st thru 90th day	All but [6.6.511(1)(b)] a day	\$[6.6.511(1)(b)] a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$[6.6.511(1)(c)] a day	\$[6.6.511(1)(c)] a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
Beyond the additional 365 days	\$0	\$0	All costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[6.6.511(1)(d)] a day \$0	\$0 Up to \$[6.6.511(1)(h)] a day \$0	\$0 Up to \$[6.6.511(1)(h)]♦ All costs
BLOOD First 3 pints Additional amounts	\$0 100%	50% \$0	50%♦ \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments♦

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

PLAN K

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

****Once you have been billed \$[13100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[13100] of Medicare approved amounts* Preventive benefits for Medicare covered services Remainder of Medicare approved amounts	\$0 Generally 75% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 10%	\$[13100] (Part B deductible)**** All costs above Medicare approved amounts Generally 10%♦

Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$[414000])*
BLOOD First 3 pints	\$0	50%	50%◆
Next \$[13100] of Medicare approved amounts*	\$0	\$0	\$[13100] (Part B deductible)****◆
Remainder of Medicare Approved amounts	Generally 80%	Generally 10%	Generally 10%
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[414000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$[13100] of Medicare approved amounts****	\$0	\$0	\$[13100] (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

(m)

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 \$[20700] each calendar year. The amounts that count toward your annual limit are noted with a diamond (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does not include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	All but \$[6.6.511(1)(a)] All but \$[6.6.511(1)(b)] a day All but \$[6.6.511(1)(c)] a day \$0 \$0	\$[6.6.511(1)(f)] (75% of Part A deductible) \$[6.6.511(1)(b)] a day \$[6.6.511(1)(c)] a day 100% of Medicare eligible expenses \$0	\$[6.6.511(1)(g)] 25% of Part A deductible♦ \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[6.6.511(1)(d)] a day \$0	\$0 Up to \$[6.6.511(1)(i)] a day \$0	\$0 Up to \$[6.6.511(1)(j)] a day♦ All costs
BLOOD First 3 pints Additional amounts	\$0 100%	75% \$0	25%♦ \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments♦

***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 \$[13100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[13100] of Medicare approved amounts****	\$0	\$0	\$[13100] (Part B deductible)****◆
Preventive benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare approved amounts	Generally 80%	Generally 15%	Generally 5%◆
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$20700])*
BLOOD First 3 pints	\$0	75%	25%◆
Next \$[13100] of Medicare approved amounts****	\$0	\$0	\$[13100] (Part B deductible)□
Remainder of Medicare Approved amounts	Generally 80%	Generally 15%	Generally 5%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[20700] 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*
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HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$[13100] of Medicare approved amounts*****	\$0	\$0	\$[13100] (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.

AUTH: 33-1-313, 33-22-904, MCA

IMP: 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905,
33-22-906, 33-22-907, 33-22-908, 33-22-909, 33-22-910, 33-22-911, 33-22-921,
33-22-922, 33-22-923, 33-22-924, MCA

REASON: It is necessary to amend this rule to reflect changes in the Federal regulations that were adopted in the NAIC Medicare Supplement Model Regulation. Federal law requires the states to adopt these rule changes by September 2009. These charts reflect the required benefits for the 1990 plan designs that can be sold until June 1, 2010, and that may remain in effect if previously issued prior to that date.

4. The rules as proposed to be adopted provide as follows:

NEW RULE I BENEFIT STANDARDS FOR 2010 STANDARDIZED
MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES
ISSUED FOR DELIVERY ON OR AFTER JUNE 1, 2010 (1) The following

standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 Standardized Medicare Supplement Benefit Plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of ARM 6.6.507 and other applicable rules and statutes contained in this subchapter and Title 33, chapter 22, part 9, MCA.

(a) The following standards are in addition to all other requirements of this subchapter and Title 33, chapter 22, part 9, MCA, Medicare Supplement Insurance Minimum Standards:

(i) a Medicare supplement policy or certificate must not exclude or limit benefits for a loss incurred more than six months from the effective date of coverage because it involves a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which

medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage;

(ii) a Medicare supplement policy or certificate must not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;

(iii) a Medicare supplement policy or certificate must provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes;

(iv) no Medicare supplement policy or certificate may 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;

(v) each Medicare supplement policy shall be guaranteed renewable and:

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

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

(vi) if the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under (1)(a)(viii), the issuer must offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):

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

(B) provides for such benefits that meet the requirements of this subsection.

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

(A) offer the certificateholder the conversion opportunity described in (1)(a)(vi); or

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

(viii) 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 must not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

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

(3) A Medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate must be suspended at the request of the policyholder or certificateholder for the period (not to exceed 24 months) in which the policyholder or certificateholder has applied for and is determined to be

entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance. Upon receipt of timely notice, the issuer must either return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility, or provide coverage to the end of the term for which premiums were paid, at the option of the insured, subject to adjustment for paid claims:

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

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

(c) reinstatement of coverages as described in (3)(a) and (b) must:

(i) not provide for any limitation with respect to treatment of preexisting conditions;

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

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

(4) Standards for basic ("core") benefits common to benefit Plans A, B, C, D, F, F with high deductible, G, M, and N include the following:

(a) every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not in lieu thereof:

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

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

(iii) 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 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

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

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

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

(b) The following additional benefits must be included in Medicare Supplement Benefit Plans B, C, D, F, and F with high deductible, G, M, and N as provided by [NEW RULE II]:

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

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

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

(iv) coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

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

(vi) coverage to the extent not covered by Medicare for 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 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.

AUTH: 33-1-313, 33-22-904, 33-22-905, MCA

IMP: 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA

REASON: It is necessary to adopt this rule to reflect changes in the Federal regulations that were adopted in the NAIC Medicare Supplement Model Regulation. Federal law requires the states to adopt these rules changes by September 2009.

New plan types will be effective June 1, 2010, and this rule reflects the new benefit standards for the new plan designs.

NEW RULE II STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY ON OR AFTER JUNE 1, 2010

(1) The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of ARM 6.6.507A.

(2) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as established in [NEW RULE I](4).

(3) If an issuer makes available any of the additional benefits described in [NEW RULE I](4)(b) or offers standardized benefits Plans K or L (as described in [NEW RULE II](8)(a) and (b) of this subchapter, then the issuer shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic core benefits as describe in (2), a policy form or certificate form containing either standardized benefit Plan C (as described in [NEW RULE II](7)(c) of this subchapter) or standardized benefit Plan F (as described in [NEW RULE II](7)(e) of this subchapter.

(4) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in [NEW RULE II](11) and ARM 6.6.601-614 of these rules.

(5) Benefit plans must be uniform in structure, language, designation and format to the standard benefit plans listed in this rule and conform to the definitions in 33-22-903, MCA, and ARM 6.6.505. Each benefit shall be structured in accordance with the format provided in [NEW RULE I](4)(a) and (b); or in the case of plans K or L, in [NEW RULE II](8)(a) and (b), and list the benefits in the order shown in this rule. For purposes of this rule, "structure, language, and format" means style, arrangement and overall content of a benefit.

(6) An issuer may use, in addition to the benefit plan designations required in (5), other designations to the extent permitted by law.

(7) The following descriptions detail the contents of the 2010 standardized benefit plans:

(a) standardized Medicare Supplement Benefit Plan A must be limited to the basic ("core") benefits common to all benefit plans, as established in [NEW RULE I](4)(a);

(b) standardized Medicare Supplement Benefit Plan B must include only the following:

(i) the core benefit as established in [NEW RULE I](4)(a), plus the Medicare Part A deductible as established in [NEW RULE I](4)(b).

(c) standardized Medicare Supplement Benefit Plan C must include only the following:

(i) the core benefit, as established in [NEW RULE I](4)(a); plus
(ii) the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, and medically necessary emergency care in a foreign country as established in [NEW RULE I](4)(b).

(d) standardized Medicare Supplement Benefit Plan D must include only the following:

(i) the core benefit, as established in ARM [NEW RULE I](4)(a); plus
(ii) the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country, as established in [NEW RULE I](4)(b).

(e) standardized Medicare Supplement Benefit Plan F must include only the following:

(i) the core benefit as established in [NEW RULE I](4)(a); plus
(ii) the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as established in [NEW RULE I](4)(b).

(f) standardized Medicare Supplement Benefit High Deductible Plan F shall include only the following:

(i) 100% of covered expenses following the payment of the annual high deductible Plan F deductible. The covered expenses include:

(A) the core benefit as defined in [NEW RULE I](4)(a); plus
(B) the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in [NEW RULE I](4)(b);

(ii) The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan F policy, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be \$1500 and shall be adjusted annually from 1999 by the Secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.

(g) standardized Medicare Supplement Benefit Plan G must include only the following:

(i) core benefit as established in [NEW RULE I](4)(a); plus
(ii) the Medicare Part A deductible, the skilled nursing facility care, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as established in [NEW RULE I](4)(b).

(8) The following descriptions detail the contents of two Medicare supplement plans mandated by the MMA:

(a) standardized Medicare Supplement Benefit Plan K must consist of only the following benefits:

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

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

(iii) 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 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for the balance;

(iv) coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in (x);

(v) coverage for 50% of the coinsurance amount for each day used for the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in (x);

(vi) coverage for 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 (x);

(vii) coverage for 50%, under Medicare Part A or B of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) unless replaced in accordance with Federal regulations until the out-of-pocket limitation is met as described in (x);

(viii) except for coverage provided in (ix) of this subsection, coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder or certificateholder pays the Part B deductible until the out-of-pocket limitation is met as described in (x);

(ix) coverage of 100% of the cost sharing for Medicare Part B preventative services after the policyholder pays the Part B deductible; and

(x) coverage of 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of \$4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary.

(b) standardized Medicare Supplement Benefit Plan L must consist of only the following benefits:

(i) the benefits described in (8)(a)(i), (ii), (iii), and (ix);

(ii) the benefit described in (8)(a)(iv), (v), (vi), (vii) and (viii), but substituting 75% for 50%; and

(iii) the benefit described in (8)(a)(x), but substituting \$2000 for \$4000.

(9) Standardized Medicare Supplement Plan M shall include only the following:

(a) the basic core benefit as defined in [NEW RULE I](4)(a), plus 50% of the Medicare Part A deductible;

(b) skilled nursing facility care, and

(c) medically necessary emergency care in a foreign country as defined in [NEW RULE I](4)(b).

(10) Standardized Medicare Supplement Plan N shall include only the following:

(a) the basic core benefit as defined in [NEW RULE I](4)(a), plus 100% of the Medicare Part A deductible;

(b) skilled nursing facility care; and

(c) medically necessary emergency care in a foreign country as defined in [NEW RULE I](4)(b), with copayments in the following amounts:

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

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

(11) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits must include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, are cost-effective, and are offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. New or innovative benefits must not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

AUTH: 33-1-313, 33-22-904, 33-22-905, MCA

IMP: 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA

REASON: It is necessary to adopt this rule to reflect changes in the Federal regulations that were adopted in the NAIC Medicare Supplement Model Regulation. Federal law requires the states to adopt these rule changes by September 2009. New plan types will be effective June 1, 2010, and this rule reflects the requirements for the new standardized benefit plans.

NEW RULE III. PROHIBITION AGAINST USE OF GENETIC INFORMATION AND REQUESTS FOR GENETIC TESTING (1) This subsection applies to all policies with policy years beginning on or after May 21, 2009. 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 preexisting condition) on the basis of the genetic information with respect to such individual; and

(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.

(2) Nothing in (1) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

(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 cannot also be used as genetic information about other group members and to further increase the premium for the group).

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

(4) Section (3) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under Part C of Title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with (1).

(5) For purposes of carrying out (4), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

(6) Notwithstanding (3), 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, Code of Federal Regulations, or equivalent Federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.

(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:

(i) compliance with the request is voluntary; and

(ii) noncompliance 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.

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

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

(8) 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.

(9) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of (8) if such request, requirement, or purchase is not in violation of (7).

(10) For the purposes of this section only:

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

(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 purposes" means:

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

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

(iii) the application of any preexisting condition exclusion under the policy;

and

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

AUTH: 33-1-313, 33-22-904, MCA

IMP: 33-22-904, 33-18-901, 33-18-902, 33-18-903, 33-18-904, MCA

REASON: It is necessary to adopt this rule to reflect changes in the Federal regulations that were adopted in the NAIC Medicare Supplement Model Regulation. The Federal Genetic Information Nondiscrimination Act requires the states to adopt these rule changes by July 2009. Discriminating on the basis of genetic information is illegal under both Montana and Federal law and this rule makes specific the prohibition.

NEW RULE IV SAMPLE FORMS OUTLINING COVERAGE (1) The following amounts, as published in the Federal Register, for services furnished in the current calendar year under Medicare's hospital insurance program (Medicare Part A), must apply to the charts for Plans A, B, C, D, F, and High Deductible Plan F, G, K, L, M, and N, issued on or after June 1, 2010, in (2)(b) through (m). In each chart, the rule cited in brackets as ARM [6.6.511(1)(a)], [6.6.511(1)(b)], [6.6.511(1)(c)], [6.6.511(1)(d)], [6.6.511(1)(e)], [6.6.511(1)(f)], [6.6.511(1)(g)], [6.6.511(1)(h)], [6.6.511(1)(i)], or [6.6.511(1)(j)], represents the dollar amount specified in the cited rule subsection. The issuer must replace each bracket and rule cite with the correct dollar amount contained in the cited rule subsection when the issuer prints the charts:

- (a) inpatient hospital deductible = \$992.00;
- (b) daily coinsurance amount for the 61st through 90th days of hospitalization in a benefit period = \$248.00;
- (c) daily coinsurance amount for lifetime reserve days = \$496.00;
- (d) daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = \$124.00;
- (e) 50% of inpatient hospital deductible = \$496.00;
- (f) 75% of inpatient hospital deductible = \$744.00;
- (g) 25% of inpatient hospital deductible = \$248.00;
- (h) 50% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = \$62.00;
- (i) 75% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = \$93.00; and
- (j) 25% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = \$31.00.

(2) The following are sample forms of the outline of coverage for Medicare supplement policies:

- (a)

COVER PAGE
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 "The Medicare Handbook" 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 rule. An issuer may use additional benefit plan designations on these charts pursuant to ARM 6.6.507A(4).]

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

(b) PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[6.6.511(1)(a)]	\$0	\$[6.6.511(1)(a)] (Part A deductible)
61st thru 90th day	All but \$[6.6.511(1)(b)] a day	\$[6.6.511(b)] a day	\$0
91st day and after: ---While using 60 lifetime reserve days	All but \$[6.6.511(1)(c)] a day	\$[6.6.511(1)(c)] a day	\$0
---Once lifetime reserve days are used: ---Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
---Beyond the additional 365 days	\$0	\$0	All costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[6.6.511(1)(d)] a day	\$0	Up to \$[6.6.511(1)(d)] a day
101 st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**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 \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, --First \$[131] of Medicare approved amounts*	\$0	\$0	\$[131] (Part B deductible)
--Remainder of Medicare approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs

BLOOD First 3 pints	\$0	All costs	\$0
Next \$[131] of Medicare ---approved amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare ---approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
---First \$[131] of Medicare approved amounts*	\$0	\$0	\$[131] (Part B deductible)
---Remainder of Medicare Approved amounts	80%	20%	\$0

(c)

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[6.6.511(1)(a)]	\$[6.6.511(1)(a)] (Part A deductible)	\$0
61st thru 90th day	All but \$[6.6.511(1)(b)] a day	\$[6.6.511(1)(b)] a day	\$0
91st day and after: ---While using 60 lifetime reserve days	All but \$[6.6.511(1)(c)] a day	\$[6.6.511(1)(c)] a day	\$0
---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	\$0 \$0	100% of Medicare eligible expenses \$0	\$0** All costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[6.6.511(1)(d)] a day	\$0	Up to \$[6.6.511(1)(d)] a day
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**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 \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$[131] (Part B deductible) \$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs

BLOOD First 3 pints	\$0	All costs	\$0
Next \$[131] of Medicare approved amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First \$[131] of Medicare approved amounts*	100%	\$0	\$0
Remainder of Medicare approved amounts	80%	20%	\$[131] (Part B deductible)
			\$0

(d) PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[6.6.511(1)(a)]	\$[6.6.511(1)(a)] (Part A deductible)	\$0
61st thru 90th day	All but \$[6.6.511(1)(b)] a day	\$[6.6.511(1)(b)] a day	\$0
91st day and after: ---While using 60 lifetime reserve days	All but \$[6.6.511(1)(c)] a day	\$[6.6.511(1)(c)] a day	\$0
---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	\$0 \$0	100% of Medicare eligible expenses \$0	\$0** All costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[6.6.511(1)(d)] a day	Up to \$[6.6.511(1)(d)] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**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 \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare approved amounts*	\$0	\$[131] (Part B deductible)	\$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[131] of Medicare approved amounts*	\$0	\$[131] (Part B deductible)	\$0
Remainder of Medicare approved amounts	80%	20%	\$0

CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
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PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment	100%	\$0	\$0
First \$[131] of Medicare approved amounts*	\$0	\$[131] (Part B deductible)	\$0
Remainder of Medicare approved amounts	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

(e) PLAN D

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

*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
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HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[6.6.511(1)(a)]	\$[6.6.511(1)(a)] (Part A deductible)	\$0
61st thru 90th day	All but \$[6.6.511(1)(a)] a day	\$[6.6.511(1)(b)] a day	\$0
91st day and after: ---While using 60 lifetime reserve days ---Once lifetime reserve days are used: ---Additional 365 days	All but \$[6.6.511(1)(c)] a day	\$[6.6.511(1)(c)] a day	\$0
---Beyond the additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[6.6.511(1)(d)] a day	Up to \$[6.6.511(1)(d)] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness			
	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**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 \$[131] 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
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MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare approved amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[131] of Medicare approved amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$[131] of Medicare approved amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare approved amounts*	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

(f) 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 \$[1860] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[1860]. 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 \$[1860] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO \$[1860] DEDUCTIBLE, **] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[6.6.511(1)(a)]	\$(6.6.511(1)(a)) (Part A deductible)	\$0
61st thru 90th day	All but [6.6.511(1)(b)] a day	\$(6.6.511(1)(b)) a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$[6.6.511(1)(c)] a day	\$(6.6.511(1)(c)) a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% Medicare eligible expenses	\$0***
Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[6.6.511(1)(d)] a day	Up to \$(6.6.511(1)(d)) a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare coinsurance/ 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 F or HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed \$[131] 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 \$[1860] deductible. Benefits from the high deductible Plan F will begin until out-of-pocket expenses are \$[1860]. 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 \$[1860] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO \$[1860] DEDUCTIBLE, **] YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare approved amounts*	\$0	\$[131] (Part B deductible)	\$0
Remainder of Medicare approved Amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (Above Medicare approved amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[131] of Medicare approved amounts*	\$0	\$[131] (Part B deductible)	\$0
Remainder of Medicare approved amounts	80%	20%	\$0
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 \$[1860] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO \$[1860] DEDUCTIBLE, **] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies	100%	\$0	\$0
---Durable medical equipment First \$[131] of Medicare approved amounts*	\$0	\$[131] (Part B deductible)	\$0
---Remainder of Medicare approved amounts	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1860] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO \$[1860] DEDUCTIBLE, **] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

(g)

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
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HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[6.6.511(1)(a)]	\$[6.6.511(1)(a)] (Part A deductible)	\$0
61st thru 90th day	All but \$[6.6.511(1)(b)] a day	\$[6.6.511(1)(b)] a day	\$0
91st day and after: ---While using 60 lifetime reserve days	All but \$[6.6.511(1)(c)] a day	\$[6.6.511(1)(c)] a day	\$0
---Once lifetime reserve days are used: ---Additional 365 days	\$0	100% Medicare eligible expenses	\$0**
---Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[6.6.511(1)(d)] a day	Up to \$[6.6.511(1)(d)] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness			
	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**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 \$[131] 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
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MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare approved amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[131] of Medicare approved amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies	100%	\$0	\$0
---Durable medical equipment First \$[131] of Medicare approved amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

(h) PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[4140] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[6.6.511(1)(a)]	[\$[6.6.511(1)(a)] (50% of Part A deductible)	[\$[6.6.511(1)(e)]♦
61st thru 90th day	All but [6.6.511(1)(b)] a day	[\$[6.6.511(1)(b)] a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$[6.6.511(1)(c)] a day	[\$[6.6.511(1)(c)] a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
Beyond the additional 365 days	\$0	\$0	All costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[6.6.511(1)(d)] a day	Up to \$[6.6.511(1)(h)] a day	Up to \$[6.6.511(1)(h)]♦
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	50% \$0	50%♦ \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	50% of copayment/ coinsurance	50% of Medicare copayment♦

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

PLAN K

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

****Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare approved amounts*	\$0	\$0	\$[131] (Part B deductible)****
Preventive benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare approved amounts	Generally 80%	Generally 10%	Generally 10%♦

Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$4140])*
BLOOD First 3 pints	\$0	50%	50%♦
Next \$[131] of Medicare approved amounts*	\$0	\$0	\$[131] (Part B deductible)****♦
Remainder of Medicare Approved amounts	Generally 80%	Generally 10%	Generally 10%
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[4140] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$[131] of Medicare approved amounts****	\$0	\$0	\$[131] (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

(i)

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 \$[2070] each calendar year. The amounts that count toward your annual limit are noted with a diamond (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does not include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	All but \$[6.6.511(1)(a)] All but \$[6.6.511(1)(b)] a day All but \$[6.6.511(1)(c)] a day \$0 \$0	\$[6.6.511(1)(f)] (75% of Part A deductible) \$[6.6.511(1)(b)] a day \$[6.6.511(1)(c)] a day 100% of Medicare eligible expenses \$0	\$[6.6.511(1)(g)] 25% of Part A deductible♦ \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[6.6.511(1)(d)] a day \$0	\$0 Up to \$[6.6.511(1)(i)] a day \$0	\$0 Up to \$[6.6.511(1)(j)] a day♦ All costs
BLOOD First 3 pints Additional amounts	\$0 100%	75% \$0	25%♦ \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment	25% of copayment/coinsurance♦

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

PLAN L

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

****Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare approved amounts****	\$0	\$0	\$[131] (Part B deductible)****◆
Preventive benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare approved amounts	Generally 80%	Generally 15%	Generally 5%◆
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$2070])*
BLOOD First 3 pints	\$0	75%	25%◆
Next \$[131] of Medicare approved amounts****	\$0	\$0	\$[131] (Part B deductible)◆
Remainder of Medicare Approved amounts	Generally 80%	Generally 15%	Generally 5%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2070] 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*
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HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$[131] of Medicare approved amounts*****	\$0	\$0	\$[131] (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.

(j)

PLAN M

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[992]	\$[496](50% of Part A deductible)	\$[496](50% of Part A deductible)
61 st through 90 th day	All but \$[248] a day	\$[248] a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$[496] a day	\$[496] a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$[124] a day	Up to \$[124] a day	\$0
101 st day and after	\$0	\$0	All costs

BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drug and inpatient respite care	Medicare copayment/ Coinsurance	\$0

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

PLAN M

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

*Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[131] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$[131] (Part B deductible) \$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[131] of Medicare approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[131] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN M

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$[131] of Medicare approved amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

(k)

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
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HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[992]	\$[992](Part A deductible)	\$0
61 st through 90 th day	All but \$[248] a day	\$[248] a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$[496] a day	\$[496] a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$[124] a day	Up to \$[124] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drug and inpatient respite care	Medicare copayment/coinsurance	\$0

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

PLAN N

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

* Once you have been billed \$[131] 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
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MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$[131] of Medicare approved amounts*	\$0	\$0	[\$131] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Balance, other than up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[131] of Medicare approved amounts*	\$0	\$0	[\$131] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
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HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$[131] of Medicare approved amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

AUTH: 33-1-313, 33-22-904, MCA

IMP: 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905,
33-22-906, 33-22-907, 33-22-908, 33-22-909, 33-22-910, 33-22-911, 33-22-921,
33-22-922, 33-22-924, MCA

REASON: It is necessary to adopt this rule to reflect changes in the Federal regulations that were adopted in the NAIC Medicare Supplement Model Regulation. Federal law requires the states to adopt these rules changes by September 2009. New plan types will be effective June 1, 2010, and these charts reflect the required benefits for those new plan designs.

5. Concerned persons may submit their data, views, or arguments concerning the proposed actions either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Christina L. Goe, Chief Legal Counsel, State Auditor's Office, 840 Helena Ave., Helena, Montana, 59601; telephone (406) 444-2040; fax (406) 444-3497; or e-mail cgoe@mt.gov, and must be received no later than 5:00 p.m., June 11, 2009.

6. Christina L. Goe, Chief Legal Counsel, has been designated to preside over and conduct this hearing.

7. The department maintains a list of concerned persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request that includes the name and mailing address of the person to receive notices and specifies for which

program the person wishes to receive notices. Such written request may be mailed or delivered to Darla Sautter, State Auditor's Office, 840 Helena Ave., Helena, Montana, 59601; telephone (406) 444-2726; fax (406) 444-3497; or e-mail dsautter@mt.gov or may be made by completing a request form at any rules hearing held by the department.

8. An electronic copy of this Proposal Notice is available through the Secretary of State's web site at <http://sos.mt.gov/ARM/Register>. The Secretary of State strives to make the electronic copy of the Notice conform to the official version of the Notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the Notice and the electronic version of the Notice, only the official printed text will be considered. In addition, although the Secretary of State works to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems.

9. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

/s/ Christina L. Goe
Christina L. Goe
Rule Reviewer

/s/ Robert W. Moon
Robert W. Moon
Deputy Insurance Commissioner

Certified to the Secretary of State May 4, 2009.