3/31/05

PROPOSED RULES

NORTH DAKOTA ADMINISTRATIVE CODE
CHAPTER 45-06-01.1
MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

Subsections 2, 11, and 12 of Section 45-06-01.1-02 – Definitions is amended as follows:

2. "Bankruptcy" means when a ~~medicare+choice~~ medicare advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

11. "~~Medicare+choice~~ Medicare advantage plan" means a plan of coverage for health benefits under medicare part C as defined in [refer to definition of ~~medicare+choice~~ medicare advantage plan in 42 U.S.C. 1395w-28(b)(1)], and includes:

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

    b. Medical savings account plans coupled with a contribution into a ~~medicare+choice~~ medicare advantage medical savings account; and

    c. ~~Medicare+choice~~ Medicare advantage private fee-for-service plans.

12. "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under section 1876 of the federal Social Security Act [42 U.S.C. 1395 et seq.] or an issued policy under the demonstration project specified in 42 U.S.C. 1395ss(g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare. "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 that provides benefits pursuant to an agreement under section 1833(a)(1)(A) of the Social Security Act.

History: Effective January 1, 1992; amended effective August 27, 1998; December 1, 2001; _____.

General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03

Law Implemented: NDCC 26.1-36.1

Subsections 4 and 7 of Section 45-06-01.1-03 – Policy Definitions and Terms is amended as follows:

4. "Health care expenses" means, for purposes of section 45-06-01.1-11, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. ~~Expenses may not include:~~

   ~~a. Home office and overhead costs;~~

   ~~b. Advertising costs;~~

   ~~c. Commissions and other acquisition costs;~~

   ~~d. Taxes;~~

   ~~e. Capital costs;~~

   ~~f. Administrative costs; and~~

   ~~g. Claims processing costs.~~

7. "Medicare eligible expenses" means expenses of the kinds covered by medicare parts A and B, to the extent recognized as reasonable and medically necessary by medicare.

History: Effective January 1, 1992; amended effective July 8, 1997; _____.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1

Section 45-06-01.1-04 – Policy Provisions is amended as follows:

45-06-01.1-04. Policy provisions.

1. Except for permitted preexisting condition clauses as described in subdivision a of subsection 1 of section 45-06-01.1-05 and subdivision a of subsection 1 of section 45-06-01.1-06, no policy or certificate may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of medicare.

2. No medicare supplement policy or certificate may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

3. No medicare supplement policy or certificate in force in the state may contain benefits which duplicate benefits provided by medicare.

4. a. Subject to subdivisions d, e, and g of subsection 1 of section 45-06-01.1-05 and subdivisions d and e of subsection 1 of section 45-06-01.1-06, a medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in part D at the option of the policyholder.

b. A medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

c. After December 31, 2005, a medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in medicare part D unless:

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

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

History: Effective January 1, 1992; amended effective July 8, 1997; _____.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

Subdivision f of subsection 1 of Section 45-06-01.1-05 – Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to January 1, 1992 is amended as follows:

f. 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 predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of medicare part D benefits will not be considered in determining a continuous loss.

g. If a medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

Subdivision f of subsection 2 of Section 45-06-01.1-05 – Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to January 1, 1992 is amended as follows:

f. 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 a maximum calendar year out-of-pocket amount equal to the medicare part B deductible (one hundred dollars).

History: Effective January 1, 1992; amended effective July 1, 1994; April 1, 1996; July 8, 1997; _____.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

Section 45-06-01.1-06 – Benefit standards for policies or certificates issued or delivered on or after January 1, 1992 is amended as follows:

45-06-01.1-06. Benefit standards for policies or certificates issued or delivered on or after January 1, 1992. The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state on or after January 1, 1992. 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:

1. **General standards.** The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this rule:

   a. A medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved 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.

   b. A medicare supplement policy or certificate may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. 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. Premiums may be modified to correspond with such changes.

d. 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.

e. Each medicare supplement policy must be guaranteed renewable:

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

(2) The issurer may not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(3) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under paragraph 5 of subdivision e of subsection 1 of section 45-06-01.1-06, the issuer must offer certificate holders an individual medicare supplement policy which at the option of the certificate holder:

(a) Provides for continuation of the benefits contained in the group policy; or

(b) Provides for benefits that otherwise meet the requirements of this subsection.

(4) If an individual is a certificate holder in a group medicare supplement policy and the individual terminates membership in the group, the issuer must:

(a) Offer the certificate holder the conversion opportunity described in paragraph 3 of subdivision e of subsection 1 of section 45-06-01.1-06; or

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

(5) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy must offer

coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) If a medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

f. 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.

g. (1) 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 certificate holder for the period, not to exceed twenty-four months, in which the policyholder or certificate holder has applied for and is determined to be entitled to ~~medicaid~~ medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396, et seq.], but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety days after the date the individual becomes entitled to assistance. Upon receipt of timely notice, the issuer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of medicaid eligibility, subject to adjustment for paid claims.

(2) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of entitlement, as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(3) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for any period that may be provided by federal regulation at the request of the policyholder if the policyholder is entitled to benefits under section

226(b) of the Social Security Act and is covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted, effective as of the date of loss of such coverage, if the policyholder provides notice of loss of coverage within ninety days after the date of such loss and pays the premium due from that date.

(4) Reinstitution of coverage as described in paragraphs 2 and 3:

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

(b) Must provide for resumption of coverage ~~which~~ that is substantially equivalent to coverage in effect before the date of suspension. If the suspended medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for medicare part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

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

2. **Standards for basic core benefits common to ~~all~~ benefit plans A through J.** Every issuer must 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~~ of it:

a. Coverage of part A medicare-eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period.

b. Coverage of part A medicare-eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used.

c. Upon exhaustion of the medicare hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent of the medicare part A eligible expenses for hospitalization paid at the ~~diagnostic-related group day outlier per diem~~ applicable prospective payment system rate, or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the ~~issuing~~ issuer's payment as payment in full and may not bill the insured for any balance.

d. 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.

e. 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.

3. **Standards for additional benefits.** The following additional benefits must be included in medicare supplement benefit plans "B" through "J" only as provided by section 45-06-01.1-07:

a. Medicare part A deductible: Coverage for all of the medicare part A inpatient hospital deductible amount per benefit period.

b. Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare part A.

c. Medicare part B deductible: Coverage for all of the medicare part B deductible amount per calendar year regardless of hospital confinement.

d. Eighty percent of the medicare part B excess charges: Coverage for eighty percent of the difference between the actual medicare part B charge as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved part B charge.

e. One hundred percent of the medicare part B excess charges: Coverage for all of the difference between the actual medicare part B charge as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved part B charge.

f. Basic outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar

calendar year deductible, to a maximum of one thousand two hundred fifty dollars in benefits received by the insured per calendar year, to the extent not covered by medicare. The outpatient prescription drug benefit may be included for sale or issuance in a medicare supplement policy until January 1, 2006.

g. Extended outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible to a maximum of three thousand dollars in benefits received by the insured per calendar year, to the extent not covered by medicare. The outpatient prescription drug benefit may be included for sale or issuance in a medicare supplement policy until January 1, 2006.

h. Medically necessary emergency care in a foreign country: Coverage to the extent not covered by medicare for eighty percent of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by medicare if provided in the United States and which care began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

i. Preventive medical care benefit: Coverage for the following preventive health services not covered by medicare:

(1) An annual clinical preventive medical history and physical examination that may include tests and services from paragraph 2 and patient education to address preventive health care measures.

(2) ~~Any one or a combination of the following preventive~~ Preventive screening tests or preventive services, the selection and frequency of which is ~~considered~~ determined to be medically appropriate~~:~~ by the attending physician.

~~(a) Digital rectal examination.~~

~~(b) Dipstick urinalysis for hematuria, bacteriuria, and proteinauria.~~

~~(c) Pure tone, air only, hearing screening test, administered or ordered by a physician.~~

~~(d) Serum cholesterol screening every five years.~~

~~(e) Thyroid function test.~~

~~(f) Diabetes screening.~~

~~(3) Tetanus and diphtheria booster every ten years.~~

~~(4) Any other tests or preventive measures determined appropriate by the attending physician.~~

Reimbursement must be for the actual charges up to one hundred percent of the medicare-approved amount for each service, as if medicare were to cover the service as identified in American medical association current procedural terminology codes, to a maximum of one hundred twenty dollars annually under this benefit. This benefit may not include payment for any procedure covered by medicare.

j. At-home recovery benefit: Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

(1) For purposes of this benefit, the following definitions apply:

(a) "Activities of daily living" includes, but is not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(b) "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a twenty-four-hour period of services provided by a care provider is one visit.

(c) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(d) "Home" means any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by medicare. A hospital or skilled nursing facility may not be considered the insured’s place of residence.

(2) Coverage requirements and limitations.

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

(b) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by medicare.

(c) Coverage is limited to:

[1] No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits may not exceed the number of medicare-approved home health care visits under a medicare-approved home care plan of treatment.

[2] The actual charges for each visit up to a maximum reimbursement of forty dollars per visit.

[3] One thousand six hundred dollars per calendar year.

[4] Seven visits in any one week.

[5] Care furnished on a visiting basis in the insured's home.

[6] Services provided by a care provider as defined in this section.

[7] At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

[8] At-home recovery visits received during the period the insured is receiving medicare-approved home care services or no more than eight weeks after the service date of the last medicare-approved home health care visit.

(3) Coverage is excluded for:

(a) Home care visits paid for by medicare or other government programs; and

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

~~k. New or innovative benefits. An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of medicare supplement policies. New or innovative benefits should offer uniquely different or significantly expanded coverages.~~

4. **Standards for Plans K and L.**

a. Standardized medicare supplement benefit plan K shall consist of the following:

(1) Coverage of one hundred percent of the part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any medicare benefit period;

(2) Coverage of one hundred percent of the part A hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any medicare benefit period;

(3) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the medicare part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(4) Medicare part A deductible: Coverage for fifty percent of the medicare part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in paragraph 10;

(5) Skilled nursing facility care: Coverage for fifty percent of the coinsurance amount for each day used from the twenty-first day

through the one hundredth 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 paragraph 10;

(6) Hospice care: Coverage for fifty percent of cost sharing for all part A medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in paragraph 10;

(7) Coverage for fifty percent, under medicare part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in paragraph 10;

(8) Except for coverage provided in paragraph 9, coverage for fifty percent of the cost sharing otherwise applicable under medicare part B after the policyholder pays the part B deductible until the out-of-pocket limitation is met as described in paragraph 10;

(9) Coverage of one hundred percent of the cost sharing for medicare part B preventive services after the policyholder pays the part B deductible; and

(10) Coverage of one hundred percent of all cost sharing under medicare parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under medicare parts A and B of four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the United States Department of Health and Human Services.

b. Standardized medicare supplement benefit plan L shall consist of the following:

(1) The benefits described in paragraphs 1, 2, 3, and 9 of subdivision a;

(2) The benefit described in paragraphs 4, 5, 6, 7, and 8 of subdivision a, but substituting seventy-five percent for fifty percent; and

(3) The benefit described in paragraph 10 of subdivision a, but substituting two thousand dollars for four thousand dollars.

History: Effective January 1, 1992; amended effective April 1, 1996; July 8, 1997; August 1, 2000; December 1, 2001; _____.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

Section 45-06-01.1-07 – Standard Medicare Supplement Benefit Plans is amended as follows:

45-06-01.1-07. Standard medicare supplement benefit plans.

1. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in subsection 2 of section 45-06-01.1-06.

2. No groups, packages, or combinations of medicare supplement benefits other than those listed in this section may be offered for sale in this state, except as may be permitted in ~~subdivision k of~~ subsection ~~3~~ 7 of section ~~45-06-01.1-06~~ 45-06-01.1-07 and in section 45-06-01.1-08.

3. Benefit plans must be uniform in structure, language, designation, and format to the standard benefit plans "A" through "J" listed in this section and conform to the definitions in section 45-06-01.1-02 and contained in North Dakota Century Code section 26.1-36.1-01. Each benefit must be structured in accordance with the format provided in subsections 2 and 3 or 4 of section 45-06-01.1-06 and list the benefits in the order shown in this section. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

4. An issuer may use, in addition to the benefit plan designations required in subsection 3, other designations to the extent permitted by law.

5. Makeup of benefit plans:

   a. Standardized medicare supplement benefit plan "A" is limited to the basic (core) benefits common to all benefit plans, as defined in subsection 2 of section 45-06-01.1-06.

   b. Standardized medicare supplement benefit plan "B" may include only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible as defined in subdivision a of subsection 3 of section 45-06-01.1-06.

   c. Standardized medicare supplement benefit plan "C" may include only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, medicare part B deductible and medically necessary emergency care in a

foreign country as defined in subdivisions a, b, c, and h of subsection 3 of section 45-06-01.1-06, respectively.

d. Standardized medicare supplement benefit plan "D" may include only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in subdivisions a, b, h, and j of subsection 3 of section 45-06-01.1-06, respectively.

e. Standardized medicare supplement benefit plan "E" may include only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in subdivisions a, b, h, and i of subsection 3 of section 45-06-01.1-06, respectively.

f. ~~(1)~~ Standardized medicare supplement benefit plan "F" may include only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, the skilled nursing facility care, the medicare part B deductible, one hundred percent of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in subdivisions a, b, c, e, and h of subsection 3 of section 45-06-01.1-06, respectively.

~~(2)~~ g. Standardized medicare supplement benefit high deductible plan "F" includes only the following: one hundred percent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, the medicare part B deductible, one hundred percent of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in subdivisions a, b, c, e, and h of subsection 3 of section 45-06-01.1-06, respectively. The annual high deductible plan "F" deductible consists of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan "F" policy, and are in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible is one thousand five hundred dollars for 1998 and 1999 and must be based on the calendar year. It must be adjusted annually thereafter by the secretary to reflect the change in the consumer price index for all urban consumers for the twelve-month period ending with August of the preceding year and rounded to the nearest multiple of ten dollars.

~~g.~~ h. Standardized medicare supplement benefit plan "G" may include only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, eighty percent of the medicare part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in subdivisions a, b, d, h, and j of subsection 3 of section 45-06-01.1-06, respectively.

~~h.~~ i. Standardized medicare supplement benefit plan "H" may consist of only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as defined in subdivisions a, b, f, and h of subsection 3 of section 45-06-01.1-06, respectively. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

~~i.~~ j. Standardized medicare supplement benefit plan "I" may consist of only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, one hundred percent of the medicare part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in subdivisions a, b, e, f, h, and j of subsection 3 of section 45-06-01.1-06, respectively. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

~~j.~~ ~~(1)~~ k. Standardized medicare supplement benefit plan "J" may consist of only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, medicare part B deductible, one hundred percent of the medicare part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in subdivisions a, b, c, e, g, h, i, and j of subsection 3 of section 45-06-01.1-06, respectively. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

~~(2)~~ l. Standardized medicare supplement benefit high deductible plan "J" consists of only the following: one hundred percent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, medicare part B deductible, one hundred percent of the medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country,

preventive medical care benefit, and at-home recovery benefit as defined in subdivisions a, b, c, e, g, h, i, and j of subsection 3 of section 45-06-01.1-06, respectively. The annual high deductible plan "J" deductible consists of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan "J" policy, and are in addition to any other specific benefit deductibles. The annual deductible is one thousand five hundred dollars for 1998 and 1999 and must be based on a calendar year. It must be adjusted annually thereafter by the secretary to reflect the change in the consumer price index for all urban consumers for the twelve-month period ending with August of the preceding year and rounded to the nearest multiple of ten dollars. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

6. Makeup of two medicare supplement plans mandated by the Medicare Prescription Drug Improvement and Modernization Act of 2003:

   a. Standardized medicare supplement benefit plan "K" shall consist of only those benefits described in subdivision a of subsection 4 of section 45-06-01.1-06.

   b. Standardized medicare supplement benefit plan "L" shall consist of only those benefits described in subdivision b of subsection 4 of section 45-06-01.1-06.

7. New or innovative benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to medicare supplement insurance, new or innovative, not otherwise available, cost effective, and offered in a manner which is consistent with the goal of simplification of medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

History: Effective January 1, 1992; amended effective July 1, 1994; August 27, 1998; _____.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

Subsections 9, 13, and 14 of Section 45-06-01.1-08 – Medicare Select Policies and Certificates are amended as follows:

9. A medicare select issuer must make full and fair disclosure in writing of the provisions, restrictions, and limitations of the medicare select policy or certificate to each applicant. This disclosure must include at least the following:

a. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the medicare select policy or certificate with:

(1) Other medicare supplement policies or certificates offered by the issuer; and

(2) Other medicare select policies or certificates.

b. A description (including address, telephone number, and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

c. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not county toward the out-of-pocket annual limit contained in plans K and L.

d. A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

e. A description of limitations on referrals to restricted network providers and to other providers.

f. A description of the policyholder's rights to purchase any other medicare supplement policy or certificate otherwise offered by the issuer.

g. A description of the medicare select issuer's quality assurance program and grievance procedure.

13. a. At the request of an individual insured under a medicare select policy or certificate, a medicare select issuer must make available to the individual insured the opportunity to purchase a medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer must make the policies or certificates available without requiring evidence of insurability after the medicare select policy or certificate has been in force for six months.

b. For the purposes of this subsection, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the medicare part A deductible, ~~coverage for prescription drugs,~~ coverage for at-home recovery services, or coverage for medicare part B excess charges.

14. Medicare select policies and certificates must provide for continuation of coverage in the event the secretary of health and human services determines that medicare select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the medicare select program to be reauthorized under law or its substantial amendment.

    a. Each medicare select issuer must make available to each individual insured under a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer must make such policies and certificates available without requiring evidence of insurability.

    b. For the purposes of this subsection, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the medicare part A deductible, ~~coverage for prescription drugs,~~ coverage for at-home recovery services, or coverage for part B excess charges.

History: Effective January 1, 1992; amended effective July 8, 1997; _____.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

Subsection 3 of Section 45-06-01.1-09 – Open Enrollment is amended as follows:

3. Except as provided in subsection ~~1 of section 45-06-01.1-20~~ 2 and sections 45-06-01.1-09.1 and 45-06-01.1-20, subsection 1 may not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

History: Effective January 1, 1992; amended effective July 8, 1997; August 27, 1998; _____.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

Section 45-06-01.1-09.1 – Guaranteed Issue for Eligible Persons is amended as follows:

45-06-01.1-09.1. Guaranteed issue for eligible persons.

1. **Guaranteed issue.**

a. Eligible persons are those individuals described in subsection 2 who seek to enroll under the policy during the period specified in subsection ~~2~~ 3, and who submit evidence of the date of termination ~~or~~, disenrollment, or medicare part D enrollment with the application for a medicare supplement policy.

b. With respect to eligible persons, an issuer may not deny or condition the issuance or effectiveness of a medicare supplement policy described in subsection 5 that is offered and is available for issuance to new enrollees by the issuer, may not discriminate in the pricing of such a medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and may not impose an exclusion of benefits based on a preexisting condition under such a medicare supplement policy.

2. **Eligible persons.** An eligible person is an individual described in any of the following subdivisions:

a. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan;

b. The individual is enrolled with a ~~medicare+choice~~ medicare advantage organization under a ~~medicare+choice~~ medicare advantage plan under part C of medicare, and any of the following circumstances apply, or the individual is sixty-five years of age or older and is enrolled with a program of all-inclusive care for the elderly provider under section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a ~~medicare+choice~~ medicare advantage plan:

(1) The organization's or plan's certification has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(2) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(3) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in

circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act, if the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856, or the plan is terminated for all individuals within a residence area;

(4) The individual demonstrates, in accordance with guidelines established by the secretary, that:

(a) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(b) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provision in marketing the plan to the individual; or

(5) The individual meets such other exceptional conditions as the secretary may provide~~;~~.

c. (1) The individual is enrolled with:

(a) An eligible organization operating under a contract under section 1876 of the Social Security Act (medicare cost);

(b) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(c) An organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(d) An organization under a medicare select policy; and

(2) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subdivision b of subsection 2;

d. The individual is enrolled under a medicare supplement policy and the enrollment ceases because:

(1) (a) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(b) Of other involuntary termination of coverage or enrollment under the policy;

(2) The issuer of the policy substantially violated a material provision of the policy; or

(3) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

e. (1) The individual was enrolled under a medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any ~~medicare+choice~~ medicare advantage organization under a medicare advantage plan under part C of medicare, any eligible organization under a contract under section 1876 of the Social Security Act (medicare cost), any similar organization operating under demonstration project authority, any program of all-inclusive care for the elderly provider under section 1894 of the Social Security Act, or a medicare select policy; and

(2) The subsequent enrollment under paragraph 1 is terminated by the enrollee during any period within the first twelve months of such subsequent enrollment, during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act; or

f. The individual, upon first becoming eligible for benefits under part A of medicare at age sixty-five, enrolls in a ~~medicare+choice~~ medicare advantage plan under part C of medicare, or in a program of all-inclusive care for the elderly program under section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve months after the effective date of enrollment.

g. The individual enrolls in a medicare part D plan during the initial enrollment period and, at the time of enrollment in part D, was enrolled under a medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the medicare supplement policy and submits evidence of enrollment in medicare part D along with the application for a policy described in subdivision d of subsection 5.

3. **Guaranteed issue time periods.**

a. In the case of an individual described in subdivision a of subsection 2, the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits or, if such notice is not received, notice that a claim has been denied because of ~~such~~ a termination or cessation; or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three days ~~after the date of the applicable notice~~ thereafter;

b. In the case of an individual described in subdivision b, c, e, or f of subsection 2 whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three days after the date the applicable coverage is terminated;

c. In the case of an individual described in paragraph 1 of subdivision d of subsection 2, the guaranteed issue period begins on the earlier of (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three days after the date the coverage is terminated;

d. In the case of an individual described in subdivision b, d, e, or f of subsection 2 who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty days before the effective date of the disenrollment and ends sixty-three days after the effective date; ~~and~~

e. In the case of an individual described in subdivision g of subsection 2, the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act from the medicare supplement issuer during the sixty-day period immediately preceding the initial part D enrollment period and ends on the date that is sixty-three days after the effective date of the individual's coverage under medicare part D; and

~~e.~~ f. In the case of an individual described in subsection 2 but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three days after the effective date.

4. **Extended medigap access for interrupted trial periods.**

a. In the case of an individual described in subdivision e of subsection 2, or deemed to be so described pursuant to this paragraph, whose enrollment with an organization or provider described in paragraph 1 of subdivision e of subsection 2 is involuntarily terminated within the first twelve months of enrollment, and who, without an intervening enrollment, enrolls with

another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in subdivision e of subsection 2;

b. In the case of an individual described in subdivision f of subsection 2, or deemed to be so described pursuant to this paragraph, whose enrollment with a plan or in a program described in subdivision f of subsection 2 is involuntarily terminated within the first twelve months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in subdivision f of subsection 2; and

c. For purposes of subdivisions e and f of subsection 2, no enrollment of an individual with an organization or provider described in paragraph 1 of subdivision e of subsection 2, or with a plan or in a program described in subdivision f of subsection 2, may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

5. **Products to which eligible persons are entitled.** The medicare supplement policy to which eligible persons are entitled under:

a. Subdivisions a, b, c, and d of subsection 2 are a medicare supplement policy that has a benefit package classified as plan A, B, C, ~~or~~ F (including F with a high deductible), K, or L offered by any issuer.

b. (1) ~~Subdivision~~ Subject to paragraph 2, subdivision e of subsection 2 is the same medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in subdivision a ~~of subsection 3~~.

(2) After December 31, 2005, if the individual was most recently enrolled in a medicare supplement policy with an outpatient prescription drug benefit, a medicare supplement policy described in this paragraph is:

(a) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(b) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K, or L policy that is offered by any issuer;

c. Subdivision f of subsection 2 includes any medicare supplement policy offered by any issuer.

d. Subdivision g of subsection 2 is 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 the individual's medicare supplement policy with outpatient prescription drug coverage.

6. **Notification provisions:**

a. At the time of an event described in subsection 2 because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of the individual's rights under this section, and of the obligations of the issuers of medicare supplement policies under subsection 1. Such notice shall be communicated contemporaneously with the notification of termination.

b. At the time of an event described in subsection 2 because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the individual's rights under this section, and of the obligations of issuers of medicare supplement policies under subsection 1. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

History: Effective August 27, 1998; amended effective December 1, 2001; _____.
General Authority: NDCC 26.1-36.1-02, 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

Subsection 1 of Section 45-06-01.1-11 – Loss Ratio Standards and Refund or Credit of Premium is amended as follows:

45-06-01.1-11. Loss ratio standards and refund or credit of premium.

1. **Loss ratio standards:**

a. (1) A medicare supplement policy form or certificate form may not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders

and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(a) At least seventy-five percent of the aggregate amount of premiums earned in the case of group policies; or

(b) At least sixty-five percent of the aggregate amount of premiums earned in the case of individual policies;

(2) Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(a) Home office and overhead costs;

(b) Advertising costs;

(c) Commissions and other acquisition costs;

(d) Taxes;

(e) Capital costs;

(f) Administrative costs; and

(g) Claims processing costs.

b. All filings of rates and rating schedules must demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions must also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

c. For purposes of applying subdivision a of subsection 1 of this section and subdivision c of subsection 3 of section 45-06-01.1-12 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) are deemed to be group policies.

d. For policies issued prior to January 1, 1992, expected claims in relation to premiums must meet:

(1) The originally filed anticipated loss ratios ~~for all individual policies, including all group policies subject to an individual loss ratio standard when issued, combined and all other group policies~~ when combined with the actual experience since inception;

(2) The appropriate loss ratio requirements from subparagraphs a and b of paragraph 1 of subdivision a when combined with actual experience beginning with July 1, 1997, to date; and

(3) The appropriate loss ratio requirement from subparagraphs a and b of paragraph 1 of subdivision a over the entire future period for which the rates are computed to provide coverage.

History: Effective January 1, 1992; amended effective July 8, 1997; _____.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-04

Section 45-06-01.1-12 – Filing and Approval of Policies and Certificates and Premium Rates is amended as follows:

45-06-01.1-12. Filing and approval of policies and certificates and premium rates.

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

2. An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug Improvement and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

~~2.~~ 3. An issuer may not use or change premium rates for a medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

~~3.~~ 4. a. Except as provided in subdivision b of this subsection, an issuer may not file for approval more than one form of a policy or certificate of each type for each standard medicare supplement benefit plan.

b. An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard medicare supplement benefit plan, one for each of the following cases:

(1) The inclusion of new or innovative benefits.

(2) The addition of either direct response or agent marketing methods.

(3) The addition of either guaranteed issue or underwritten coverage.

(4) The offering of coverage to individuals eligible for medicare by reason of disability.

c. For the purposes of this section, a "type" means an individual policy, a group policy, an individual medicare select policy, or a group medicare select policy.

~~4.~~ 5. a. Except as provided in paragraph 1, an issuer must continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the commissioner. A policy form or certificate form may not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months.

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

(2) An issuer that discontinues the availability of a policy form or certificate form pursuant to paragraph 1 may not file for approval a new policy form or certificate form of the same type for the same standard medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

b. The sale or other transfer of medicare supplement business to another issuer is considered a discontinuance for the purposes of this subsection.

c. A change in the rating structure or methodology is considered a discontinuance under subdivision a unless the issuer complies with the following requirements:

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

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

~~5.~~ 6. a. Except as provided in subdivision b, the experience of all policy forms or certificate forms of the same type in a standard medicare supplement benefit plan must be combined for purposes of the refund or credit calculation prescribed in section 45-06-01.1-11.

b. Forms assumed under an assumption reinsurance agreement may not be combined with the experience of other forms for purposes of the refund or credit calculation.

History: Effective January 1, 1992; amended effective July 1, 1994; _____.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

Section 45-06-01.1-14 – Required Disclosure Provisions is amended as follows:

45-06-01.1-14. Required disclosure provisions.

1. **General rules.**

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

b. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a medicare supplement policy, or is required to reduce or eliminate

benefits to avoid duplication of medicare benefits, all riders or endorsements added to a medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy must require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for medicare supplement policies, or if the increased benefits or coverage is required by law. When a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge must be set forth in the policy.

c. Medicare supplement policies or certificates may not provide for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import.

d. If a medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph of the policy and be labeled as "preexisting condition limitations".

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

f. (1) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for medicare must provide to those applicants a guide to health insurance for people with medicare in the form developed jointly by the national association of insurance commissioners and the ~~health care financing administration~~ centers for medicare and medicaid services and in a type size no smaller than twelve-point type. Delivery of the guide must be made whether or not such policies or certificates are advertised, solicited, or issued as medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the guide must be made to the applicant at the time of application and acknowledgment of receipt of the guide must be obtained by the insurer. Direct response issuers must deliver the guide to the applicant upon request but not later than at the time the policy is delivered.

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

2. **Notice requirements.**

a. As soon as practicable, but no later than thirty days prior to the annual effective date of any medicare benefit changes, an issuer must notify its policyholders and certificate holders of modifications it has made to medicare supplement insurance policies or certificates in a format acceptable to the commissioner. The notice must:

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

(2) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in medicare.

b. The notice of benefit modifications and any premium adjustments must be in outline form and in clear and simple terms so as to facilitate comprehension.

c. Such notices may not contain or be accompanied by any solicitation.

3. **Medicare Prescription Drug Improvement and Modernization Act of 2003 notice requirements.**

Issuers must comply with any notice requirements of the Medicare Prescription Drug Improvement and Modernization Act of 2003.

~~3.~~ 4. **Outline of coverage requirements for medicare supplement policies.**

a. Issuers must provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, must obtain an acknowledgment of receipt of the outline from the applicant; and

b. If an outline of coverage is provided at the time of application and the medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve-point type, immediately above the company name:

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

c. The outline of coverage provided to applicants pursuant to this section must consist of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage must be in the language and format prescribed below in no less than twelve-point type. All plans "A" through ~~"J"~~ "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 must be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant must be illustrated.

d. 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 Plans _____[insert letters of plans being offered

~~Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans. This chart shows~~ These charts show the benefits included in each ~~plan~~ of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state.

See Outlines of Coverage sections for details about ALL plans

Basic Benefits for Plans A - J: ~~Included in All Plans.~~
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~~, in the case of hospital outpatient department services under a prospective payment system, applicable~~ copayments for hospital outpatient services.
Blood: First three pints of blood each year.

A	B	C	D	E	F F*	G	H	I	J J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							~~Basic Drugs ($1,250 Limit)~~	~~Basic Drugs ($1,250 Limit)~~	
				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 ~~or offer the same~~ benefits as Plans F and J after one has paid a calendar year ~~[$1530]~~ [$1690] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses ~~are [$1,530]~~ exceed [$1690]. 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 ~~does~~ do not include~~, in Plan J,~~ the plan's separate ~~prescription drug deductible or, in Plans F and J, the plan's~~ foreign travel emergency deductible.

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

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	$[4000] Out of Pocket Annual Limit***	$[2000] Out of Pocket Annual Limit***

**** Plans K and L provide for different cost-sharing for items and services than Plans A – J.**

Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

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

See Outlines of Coverage for details and exceptions.

PREMIUM INFORMATION [Boldface Type]

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

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

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

RIGHT TO RETURN POLICY [Boldface Type]

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

POLICY REPLACEMENT [Boldface Type]

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

NOTICE [Boldface Type]

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

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

[for direct response:]
[insert company's name] is not connected with Medicare.

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

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

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

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

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to ~~Section 9D of this regulation~~ Section 45-06-01.1-07(4).]

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~[$792]~~ $[876]	$0	~~$[792]~~ $[876] (Part A deductible)
61st thru 90th day	All but ~~$[198]~~ [$219] a day	~~$[198]~~ $[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~$[396]~~ [$438] a day	~~$[396]~~ $[438] 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	$0
21st thru 100th day	All but ~~$[99]~~ $[109.50] a day	$0	Up to ~~$[99]~~ $[109.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient 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 A

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

* Once you have been billed ~~$100~~ $[100] 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 ~~$100~~ $[100] of Medicare Approved Amounts*	$0	$0	~~$100~~ $[100] (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 ~~$100~~ $[100] of Medicare Approved Amounts*	$0	$0	~~$100~~ $[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—~~BLOOD~~ 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	100%	$0	$0
First ~~$100~~ $[100] of Medicare Approved Amounts*	$0	$0	~~$100~~ $[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$[792]~~ $[876]	~~$[792]~~ $[876](Part A deductible)	$0
61st thru 90th day	All but ~~$[198]~~ $[219] a day	~~$[198]~~ $[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~$[396]~~ $[438] a day	~~$[396]~~ $[438] 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	$0
21st thru 100th day	All but ~~$[99]~~ $[109.50] a day	$0	Up to ~~$[99]~~ $[109.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient 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 B

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

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

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$[792]~~ $[876]	~~$[792]~~ $[876](Part A deductible)	$0
61st thru 90th day	All but ~~$[198]~~ $[219] a day	~~$[198]~~ $[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~$[396]~~ $[438] a day	~~$[396]~~ $[438] 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	$0
21st thru 100th day	All but ~~$[99]~~ $[109.50] a day	Up to ~~$[99]~~ $[109.50] 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 out-patient 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 C

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

* Once you have been billed ~~$100~~ $[100] 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 ~~$100~~ $[100] of Medicare Approved Amounts*	$0	~~$100~~ $[100] (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 ~~$100~~ $[100] of Medicare Approved Amounts*	$0	~~$100~~ $[100] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—~~BLOOD~~ TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First ~~$100~~ $[100] of Medicare Approved Amounts*	$0	~~$100~~ $[100] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
OTHER BENEFITS—NOT COVERED BY MEDICARE			
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$[792]~~ $[876]	~~$[792]~~ $[876] (Part A deductible)	$0
61st thru 90th day	All but ~~$[198]~~ $[219] a day	~~$[198]~~ $[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~$[396]~~ $[438] a day	~~$[396]~~ $[438] a day $0	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0** All costs
—Beyond the additional 365 days	$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	$0
21st thru 100th day	All but ~~$[99]~~ $[109.50] a day	Up to ~~$[99]~~ $[109.50] 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 out-patient 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 ~~$100~~ $[100] 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 ~~$100~~ $[100] of Medicare Approved Amounts*	$0	$0	~~$100~~ $[100] (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 ~~$100~~ $[100] of Medicare Approved Amounts*	$0	$0	~~$100~~ $[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES~~—BLOOD~~ TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN D

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$[792]~~ $[876]	~~$[792]~~ $[876] (Part A deductible)	$0
61st thru 90th day	All but ~~$[198]~~ $[219] a day	~~$[198]~~ $[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~$[396]~~ $[438] a day	~~$[396]~~ $[438] 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	$0
21st thru 100th day	All but ~~$[99]~~ $[109.50] a day	Up to ~~$[99]~~ $[109.50] 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 out-patient 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 E

MEDICARE (PART B)—MEDICAL SERVICES—PER BENEFIT PERIOD

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

(continued)

PLAN E

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$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 ~~such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education,~~ 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.*

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 ~~or offers the same~~ benefits as Plan F after one has paid a calendar year ~~$[1580]~~ [$1690] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are ~~$[1580]~~ [$1690]. 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 ~~$[1580]~~ $[1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO ~~$[1580]~~ $[1690] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$[792]~~ $[876]	~~$[792]~~ $[876] (Part A deductible)	$0
61st thru 90th day	All but ~~$[198]~~ $[219] a day	~~$[198]~~ $[219] a day	$0
91st day and after:			
While using 60 Lifetime reserve days	All but ~~$[396]~~ $[438] a day	~~$[396]~~ $[438] 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	$0
21st thru 100th day	All but ~~$[99]~~ $[109.50] a day	Up to ~~$[99]~~ $[109.50] 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 out-patient drugs and inpatient respite care	$0	Balance

(continued)

***** 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 ~~$100~~ $[100] 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 ~~or offers the~~ same benefits as Plan F after one has paid a calendar year ~~$[1580]~~ [$1690] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are ~~$[1580]~~ [$1690]. 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 ~~$[1580]~~ $[1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO ~~$[1580]~~$[1690] 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 ~~$100~~ $[100] of Medicare Approved amounts*	$0	~~$100~~ $[100] (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 ~~$100~~ $[100] of Medicare Approved amounts*	$0	~~$100~~ $[100] (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES ~~BLOOD~~ TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$[1580]~~ $[1690] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$[1580]~~ $[1690] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First ~~$100~~ $[100] of Medicare approved Amounts*	$0	~~$100~~ $[100] (Part B deductible)	$0
Remainder of Medicare approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$[1580]~~ $[1690] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$[1580]~~ $[1690] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$[792]~~ $[876]	~~$[792]~~ $[876] (Part A deductible)	$0
61st thru 90th day	All but ~~$[198]~~ $[219] a day	~~$[198]~~ $[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~$[396]~~ $[438] a day	~~$[396]~~ $[438] 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	$0
21st thru 100th day	All but ~~$[99]~~ $[109.50] a day	Up to ~~$[99]~~ $[109.50] 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 out-patient 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 ~~$100~~ $[100] 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 ~~$100~~ $[100] of Medicare Approved Amounts*	$0	$0	~~$100~~ $[100] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All costs	$0
Next ~~$100~~ $[100] of Medicare Approved Amounts*	$0	$0	~~$100~~ $[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES~~—BLOOD~~ TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN H

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$[792]~~ $[876]	~~$[792]~~ $[876] (Part A deductible)	$0
61st thru 90th day	All but ~~$[198]~~ $[219] a day	~~$[198]~~ $[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~$[396]~~ $[438] a day	~~$[396]~~ $[438] 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	$0
21st thru 100th day	All but ~~$[99]~~ $[109.50] a day	Up to ~~$[99]~~ $[109.50] 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 out-patient 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 ~~$100~~ $[100] 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 ~~$100~~ $[100] of Medicare Approved Amounts*	$0	$0	~~$100~~ $[100] (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 ~~$100~~ $[100] of Medicare Approved Amounts*	$0	$0	~~$100~~ $[100] (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 ~~$100~~ $[100] of Medicare Approved Amounts*	$0	$0	~~$100~~ $[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued)

PLAN H

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum
~~**BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE**~~			
~~First $250 each calendar year~~	~~$0~~	~~$0~~	~~$250~~
~~Next $2,500 each calendar year~~	~~$0~~	~~50% $1,250 calendar year maximum benefit~~	~~50%~~
~~Over $2,500 each calendar year~~	~~$0~~	~~$0~~	~~All costs~~

PLAN I

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$[792]~~ $[876]	~~$[792]~~ $[876] (Part A deductible)	$0
61st thru 90th day	All but ~~$[198]~~ $[219] a day	~~$[198]~~ $[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~$[396]~~ $[438] a day	~~$[396]~~ $[438] 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	$0
21st thru 100th day	All but ~~$[99]~~ $[109.50] a day	Up to ~~$[99]~~ $[109.50] 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 out-patient 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 ~~$100~~ $[100] 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 ~~$100~~ $[100] of Medicare Approved Amounts*	$0	$0	~~$100~~ $[100] (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 ~~$100~~ $[100] of Medicare Approved Amounts*	$0	$0	~~$100~~ $[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—~~BLOOD~~ TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN I

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First ~~$100~~ $[100] of Medicare Approved Amounts*	$0	$0	~~$100~~ $[100] (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 Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum
~~**BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVEREDF BY MEDICARE**~~			
~~First $250 each calendar year~~	~~$0~~	~~$0~~	~~$250~~
~~Next $2,500 each calendar year~~	~~$0~~	~~50% $1,250 calendar year maximum benefit~~	~~50%~~
~~Over $2,500 each calendar year~~	~~$0~~	~~$0~~	~~All costs~~

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 ~~or offers the same~~ benefits as Plan J after one has paid a calendar year ~~$[1580]~~ [$1690] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are ~~$[1580]~~ [$1690]. 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 outpatient prescription drug deductible or the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY ~~$[1580]~~ $[1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO ~~$[1580]~~ $[1690] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$[792]~~ $[876]	~~$[792]~~ $[876] (Part A deductible)	$0
61st thru 90th day	All but ~~$[198]~~ $[219] a day	~~$[198]~~ $[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~$[396]~~ $[438] a day	~~$[396]~~ $[438] 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	$0
21st thru 100th day	All but ~~$[99]~~ $[109.50] a day	Up to ~~$[99]~~ $[109.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

(continued)

***** 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 ~~$100~~ $[100] 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 ~~or offers the same~~ benefits as Plan J after one has paid a calendar year ~~$[1580]~~ [$1690] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are ~~$[1580]~~ [$1690]. 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 outpatient prescription drug deductible or the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY ~~$[1580]~~ $[1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO ~~$[1580]~~ $[1690] DEDUCTIBLE,**] YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First ~~$100~~ $[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 Generally 80%	~~$100~~ $[100] (Part B deductible) Generally 20%	$0 $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next ~~$100~~ $[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 $0 80%	All Costs ~~$100~~ $[100] (Part B deductible) 20%	$0 $0 $0
CLINICAL LABORATORY SERVICES—~~BLOOD~~ TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$[1580]~~ $[1690] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$[1580]~~ $[1690] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First ~~$100~~ $[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 ~~$100~~ $[100] (Part B deductible) 20%	$0 $0 $0
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan —Benefit for each visit —Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit) —Calendar year maximum	$0 $0 $0	Actual charges to $40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week $1,600	Balance

(continued)

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$[1580]~~ $[1690] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$[1580]~~ $[1690] 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
~~**EXTENDED OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE**~~			
~~First $250 each calendar year~~	~~$0~~	~~$0~~	~~$250~~
~~Next $6,000 each calendar year~~	~~$0~~	~~50% $3,000 calendar year maximum benefit~~	~~50%~~
~~Over $6,000 each calendar year~~	~~$0~~	~~$0~~	~~All costs~~
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services ~~such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education,~~ 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*.

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[4000] 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 $[876]	$[438](50% of Part A deductible)	$[438](50% of Part A deductible)♦
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] 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 $[109.50] a day	Up to $[54.75] a day	Up to $[54.75] a day ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%♦
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments♦

(continued)

***** 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 $[100] 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 $[100] of Medicare Approved Amounts****	$0	$0	$[100] (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 [$4000])*
BLOOD			
First 3 pints	$0	50%	50%♦
Next $[100] of Medicare Approved Amounts****	$0	$0	$[100] (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

***** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4000] 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 $[100] of Medicare Approved Amounts*****	$0	$0	$[100] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	10%	10%♦

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

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[2000] 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 $[876]	$[657] (75% of Part A deductible)	$[219] (25% of Part A deductible)♦
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] 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 $[109.50] a day	Up to $[82.13] a day	Up to $[27.37] a day♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%♦
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments ♦

(continued)

*** **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 $[100] 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,			
rst $[100] of Medicare Approved Amounts****	$0	$0	$[100] (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 [$2000])*
BLOOD			
First 3 pints	$0	75%	25%♦
Next $[100] of Medicare Approved Amounts****	$0	$0	$[100] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2000] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN L

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[100] of Medicare Approved Amounts*****	$0	$0	$[100] (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*.

~~4.~~ 5. **Notice regarding policies or certificates that are not medicare supplement policies.**

a. Any accident and sickness insurance policy or certificate, other than a medicare supplement policy; a policy issued pursuant to a contract under section 1876 of the Social Security Act [42 U.S.C. 1395 et seq.]; disability income policy; or other policy identified in subsection 2 of section 45-06-01.1-01, issued for delivery in this state to persons eligible for medicare, must notify insureds under the policy that the policy is not a medicare supplement policy or certificate. The notice must either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice must be in no less than twelve-point type and must contain the following language:

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

b. Applications provided to persons eligible for medicare for the health insurance policies for certificates described in subdivision a must disclose, using the applicable statement in appendix C, the extent to which the policy duplicates medicare. The disclosure statement must be provided as a part of, or together with, the application for the policy or certificate.

History: Effective January 1, 1992; amended effective August 1, 1992; July 1, 1994; April 1, 1996; July 1, 1998; August 27, 1998; December 1, 2001; _____.
General Authority: NDCC 26.1-36.1-03, 26.1-36.1-05
Law Implemented: NDCC 26.1-36.1-05

Section 45-06-01.1-15 – Requirements for Application Forms and Replacement Coverage is amended as follows:

45-06-01.1-15. Requirements for application forms and replacement coverage.

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

[Statements]

1. You do not need more than one Medicare supplement policy.

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

3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

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

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

~~5.~~ 6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement

insurance and concerning medical assistance through the state medical assistance program, including benefits as a qualified medicare beneficiary (QMB) and a special low-income medicare beneficiary (SLMB).

[Questions]

~~To the best of your knowledge,~~

~~1. Do you have another Medicare supplement policy or certificate in force?~~

~~a. If so, with which company?~~

~~b. If so, do you intend to replace your current Medicare supplement policy with this policy (certificate)?~~

~~2. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?~~

~~a. If so, with which company?~~

b. What kind of policy?

~~3. Are you covered for medical assistance through the state Medicaid program:?~~

~~a. As a specified low-income medicare beneficiary (SLMB)?~~

~~b. As a qualified medicare beneficiary (QMB)?~~

~~c. For other Medicaid medical benefits?~~

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

[Please mark Yes or No below with an "X"]

To the best of your knowledge,

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

Yes____ No____

b. Did you enroll in Medicare Part B in the last 6 months?

Yes____ No____

c. If yes, what is the effective date? _____

2. Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes____ No____

If yes,

a. Will Medicaid pay your premiums for this Medicare supplement policy?

Yes____ No____

b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes____ No____

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

START __/__/__ END __/__/__

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

Yes____ No____

c. Was this your first time in this type of Medicare plan?

Yes____ No____

d. Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes____ No____

4. a. Do you have another Medicare supplement policy in force?

Yes____ No____

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

_____

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

Yes____ No____

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

Yes____ No____

a. If so, with what company and what kind of policy?

_____

_____

_____

_____

b. What are your dates of coverage under the other policy?

START __/__/__ END __/__/__

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

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

a. List policies sold which are still in force.

b. List policies sold in the past five years which are no longer in force.

3. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, must be returned to the applicant by the insurer upon delivery of the policy.

4. Upon determining that a sale will involve replacement of medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, must furnish the applicant, prior to issuance or delivery of the medicare supplement policy or certificate, a notice regarding replacement of medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, must be provided to the applicant and an additional signed copy must be retained by the issuer. A direct response issuer must deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of medicare supplement coverage.

5. The notice required by subsection 4 for an issuer must be provided in substantially the following form in no less than twelve-point type:

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

[Insurance company's name and address]

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

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

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

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

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

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ My plan has outpatient prescription drug coverage and I am enrolling Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers.]

_____

_____

_____ Other. (please specify)

_____
_____
_____

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

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

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

_____
(Signature of Agent, Broker or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

_____
(Applicant's Signature)

_____
(Date)

*Signature not required for direct response sales.

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

History: Effective January 1, 1992; amended effective July 1, 1994; April 1, 1996; July 8, 1997; _____.
General Authority: NDCC 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02, 26.1-36.1-05

Section 45-06-01.1-18 – Appropriateness of Recommended Purchase and Excessive Insurance is amended as follows:

45-06-01.1-18. Appropriateness of recommended purchase and excessive insurance.

1. In recommending the purchase or replacement of any medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

2. Any sale of a medicare supplement ~~coverage~~ policy or certificate that will provide an individual more than one medicare supplement policy or certificate is prohibited.

3. An issuer shall not issue a medicare supplement policy or certificate to an individual enrolled in medicare part C unless the effective date of the coverage is after the termination date of the individual's part C coverage.

History: Effective January 1, 1992; amended effective _____.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

Section 45-06-01.1-20 – Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods, and Probationary Periods in Replacement Policies or Certificates is amended as follows:

45-06-01.1-20. Prohibition against preexisting conditions, waiting periods, elimination periods, and probationary periods in replacement policies or certificates.

1. If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate, the replacing issuer must waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new medicare supplement policy or certificate <u>for similar benefits</u> to the extent such time was spent under the original policy.

2. If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy may not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods <u>for benefits similar to those contained in the original policy or certificate</u>.

History: Effective January 1, 1992<u>; amended effective _____</u>.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

APPENDIX A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR_____

TYPE[1]_____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code_____
Address_____ Person Completing Exhibit_____
Title _____ Telephone Number _____

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

Medicare Supplement Credibility Table

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

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

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title_____ Telephone Number_____

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

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

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

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

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

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR CALENDAR YEAR_____

TYPE[1]_____ SMSBP[2] _____
For the State of_____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address_____ Person Completing Exhibit_____
Title _____ Telephone Number_____

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

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

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans

[3] Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

[4] For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

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

[6] To include the earned premium for all years prior to as well as the 15th year prior to the current year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR_____

TYPE[1]_____ SMSBP[2] _____
For the State of_____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address_____ Person Completing Exhibit_____
Title _____ Telephone Number_____

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

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

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans

[3] Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

[4] For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

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

[6] To include the earned premium for all years prior to as well as the 15th year prior to the current year.

APPENDIX B – NO CHANGES

APPENDIX C

DISCLOSURE STATEMENTS

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

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

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

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

Before You Buy This Insurance

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

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

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

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

Before You Buy This Insurance

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

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state ~~senior~~ [health] insurance ~~counseling~~ [assistance] program [SHIP].

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

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

This is not Medicare Supplement Insurance

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

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

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

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state ~~senior~~ [health] insurance ~~counseling~~ [assistance] program [SHIP].

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

Medicare generally pays for most or all of these expenses.

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

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state ~~senior~~ [health] insurance ~~counseling~~ [assistance] program [SHIP].

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

Medicare generally pays for most or all of these expenses.

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

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state ~~senior~~ [health] insurance ~~counseling~~ [assistance] program [SHIP].

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state ~~senior~~ [health] insurance ~~counseling~~ [assistance] program [SHIP].

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

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

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

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

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state ~~senior~~ [health] insurance ~~counseling~~ [assistance] program [SHIP].

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

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

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

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

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

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

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state ~~senior~~ [health] insurance ~~counseling~~ [assistance] program [SHIP].

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

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

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

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

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

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

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

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

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

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

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

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

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

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THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
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[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

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

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

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

Medicare generally pays for most or all of these expenses.

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

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

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

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√ Check the coverage in **all** health insurance policies you already have.

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

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THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
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Before You Buy This Insurance

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