NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* 1st as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Arizona Administrative Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

PREAMBLE

1. **Sections Affected** — **Rulemaking Action**
   R20-5-627 — New Section

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**
   Authorizing statute: A.R.S. § 23-405(4)

   Implementing statute: A.R.S. § 23-410

3. **The effective date of the rules:**
   June 26, 1998

4. **A list of all previous notices appearing in the Register addressing the final rule:**
   Notice of Rulemaking Docket Opening: 3 A.A.R. 2034, August 1, 1997.

   Notice of Proposed Rulemaking: 4 A.A.R. 354, February 6, 1998.

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**
   Name: Cathy Neville, Assistant Director

   Address: Division of Occupational Safety and Health
   Industrial Commission of Arizona
   800 West Washington Street, Suite 203
   Phoenix, Arizona 85007

   Telephone: (602) 542-1695

   Fax: (602) 542-1614

6. **An explanation of the rules, including the agency's reasons for initiating the rules:**
   The new rule language will enable the Division to conform to the adoption of a federal Occupational Safety and Health rule published in the *Federal Register* of March 31, 1997 requiring those employers who have received a citation for a violation of the Occupational Safety and Health Act to certify that a hazardous condition for which they were cited is abated and to inform affected employees of the abatement action taken by their employers. The abatement procedures an employer must follow depend on the nature of the violation identified and the employer's abatement actions. If abatement occurs during or immediately after the inspection identifying the violation, the employer is not required to submit an abatement certification letter to the Division. If the violation is a nonserious violation, or a serious violation that does not require additional documentation (as defined by OSHA), the employer is required to certify abatement using a simple 1-page form or equivalent. The rule codifies, simplifies, and streamlines the abatement certification procedures that the Division previously administered. The Division feels that this abatement verification rule will reduce employers' paperwork, enhance employee participation in the abatement process, increase the number of cited hazards that are quickly abated, and streamline and standardize the Division's abatement procedures.

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**
   Not applicable.

8. **The summary of the economic, small business, and consumer impact:**
   The federal Occupational Safety and Health Administration has determined that this rule will reduce the costs that cited employers currently incur to verify abatement. This conclusion is based on; (1) the fact that the final rule will only affect those employers who are actually cited for a violation, and (2) evidence that most of these cited employers already supply federal and state-

plan enforcement agencies with more information than required under the new rule. Overall, the cost of compliance for employers to verify abatement under the new rule is estimated to be 50% less per year than employers are currently incurring to comply with the administrative procedures for abatement verification.

Other benefits of the new rule include enhanced worker protection because hazards will be abated more quickly. Cost and benefit analysis of the rule is available for inspection, review, and copying at the Industrial Commission of Arizona, Division of Occupational Safety and Health, 800 West Washington Street, Phoenix, Arizona 85007.

9. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**
There were changes made due to suggestions and comments made by the Secretary of State's office and GRRC staff with regard to clarity, conciseness, punctuation, and style. No substantive changes were made which differ from the Notice of Proposed Rulemaking.

10. **A summary of the principal comments and the agency response to them:**
No comments, either oral or written were received.

11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**
Not applicable.

12. **Incorporations by reference and their location in the rules:**
None.

13. **Was this rule previously adopted in an emergency rule?**
No.

14. **The full text of the rules follows:**

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

ARTICLE 6. OCCUPATIONAL SAFETY AND HEALTH CONSTRUCTION STANDARDS

Section
R20-5-627. Abatement verification
Appendix A
Appendix B
Appendix C

ARTICLE 6. OCCUPATIONAL SAFETY AND HEALTH CONSTRUCTION STANDARDS

R20-5-627. Abatement Verification

A. Scope and application.
This Section applies to employers, as defined in A.R.S. § 23-401, who receive a citation for a violation of the Arizona Occupational Safety and Health Act.

B. Definitions:
1. Abatement means action by an employer to comply with a cited standard or rule or to eliminate a recognized hazard, as defined in A.R.S. § 23-401, identified by the Division during an inspection.
2. Abatement date means:
   a. For an uncontested citation item, the later of:
      i. The date in the citation for abatement of the violation;
      ii. The date approved by the Division as a result of a petition for modification of the abatement date (PMA); or
      iii. The date for abatement completion as established in a citation by an informal conference agreement.
   b. For a contested citation item for which an administrative law judge has issued a final decision affirming the violation, the later of:
      i. The date identified in the final decision for completion of abatement;
      ii. The date computed by adding the original period allowed for abatement in the citation to begin 15 days from the final decision date of an administrative law judge; or
      iii. The date established by a formal settlement agreement.
3. Affected employee means an employee who is exposed to the hazard identified as a violation in a citation.
4. Final order date means:
   a. The date on which an uncontested citation is deemed final under A.R.S. § 23-417 (A); or
   b. For a contested citation item:
      The date on which a decision or order of an administrative law judge becomes final under A.R.S. § 23-421 or § 23-423.
5. Movable equipment means a hand-held or non-hand-held machine or device, powered or unpowered, that is used to do work and is moved within or between workplaces.

C. Abatement certification.
1. Within 10 calendar days after the abatement date, an employer shall certify to the Division that the employer has abated each cited violation except as provided in subsection (C)(2). An employer may use Appendix A to certify abatement.
2. An employer is not required to certify abatement if a Compliance Safety and Health Officer, during an on-site inspection:
   a. Observes, within 24 hours after a violation is identified, that abatement has occurred; and
   b. Notes the abatement action on the citation.
3. An employer's certification that abatement is complete shall include, for each cited violation, in addition to the information required by subsection (H), the completion date and method of abatement and a statement that

affected employees and their representatives have been informed of the completed abatement.

D. Abatement documentation.
1. Within 10 days after the abatement date, an employer shall submit to the Division, documents which evidence that abatement is complete for each willful or repeat violation and for any serious violation for which abatement documentation is required.
2. Documents which evidence that abatement is complete may include documents for purchase or repair of equipment, photographs or videos of the abatement, or other written records.

E. Abatement plans.
1. The Division may require an employer to submit an abatement plan, except for a nonserious violation, when the time permitted for abatement is more than 90 days. The citation shall state that an abatement plan is required. An employer may use Appendix B for an abatement plan.
2. An employer shall submit an abatement plan for each cited violation within 25 days from the date of a final order when the citation states that a plan is required. In the abatement plan, the employer shall identify:
   a. The violation,
   b. The steps necessary to achieve abatement,
   c. A schedule for completing abatement, and
   d. How the employer will protect employees from the violative condition until abatement is complete.

F. Progress reports.
1. The Division may require an employer who submits an abatement plan under subsection (E), to submit periodic progress reports for each cited violation. If the Division requires a periodic progress report, the citation shall include the following information:
   a. Periodic progress reports are required and the cited violations for which periodic progress reports are required;
   b. The date on which an initial progress report must be submitted. The date of the initial progress report shall be no sooner than 30 days after the submission date required for abatement;
   c. Whether additional progress reports are required; and
   d. The date on which additional progress reports shall be submitted.
2. For each violation, the employer shall summarize in the progress report, the action taken to achieve abatement and the date the action was taken.

G. Employee notification.
1. An employer shall inform affected employees and the employees' representative of abatement activities covered by this Section by posting a copy of each document submitted to the Division or a summary of the document at the location of the cited violation.
2. For employers who have mobile work operations, the employer shall:
   a. Post each document or a summary of the document submitted to the Division in a conspicuous place where it can be readily seen by employees and the employee representative; or
   b. Take other steps to communicate fully to affected employees and the employees' representative about abatement actions.
3. The employer shall inform employees and the employees' representative of the right to examine and copy all abatement documents submitted by the employer to the Division.
   a. An employee or an employee representative shall submit a written request to examine and copy abatement documents within 3 working days of receiving notice that the documents have been submitted to the Division.
   b. An employer shall comply with an employee's or employee representative's written request to examine and copy abatement documents within 5 working days of receiving the request.
4. An employer shall ensure that notice in subsection (G)(1) to employees and a employee representative is provided at the same time or before the information is provided to the Division and that abatement documents are:
   a. Not altered, defaced, or physically covered by other material; and
   b. Remain posted for at least 3 working days after submission to the Division.

H. Transmitting abatement documents.
1. An employer shall include, in each submission required by this Section, the following information:
   a. The employer's name and address;
   b. The inspection number to which the submission relates;
   c. The citation, item number, and location to which the submission relates;
   d. A statement that the information submitted is accurate; and
   e. The signature of the employer or the employer's authorized representative.
2. The date of postmark is the date of submission for mailed documents. For documents transmitted by other means, the date the Division receives the document is the date of submission.

I. Movable equipment.
1. For serious, repeat, and willful violations involving movable equipment, an employer shall attach a warning tag or a copy of the citation to the operating controls or to the cited component of equipment that is moved within or between workplaces. The Division shall deem attaching a copy of the citation to the equipment to meet the tagging requirement of subsection (I)(3) and the posting requirement of R20-5-623.
2. The employer shall use a warning tag to warn employees about the nature of the violation involving the movable equipment and identifies the location of the violation. An employer may use the tag in Appendix C to meet this requirement.
3. If a violation has not been abated, an employer shall attach a warning tag or a copy of the citation to the equipment as follows:
   a. For hand-held equipment, the employer shall attach a warning tag or copy of the citation within 8 hours after the employer receives the citation; and
   b. For non-hand-held equipment, the employer shall attach a warning tag or copy of the citation before moving the equipment within or between workplaces.
4. For the construction industry, a tag that is designed and used in accordance with 29 CFR 1926.20(b)(3) and 29 CFR 1926.200(h) is deemed by the Division to meet the requirements of this Section when the information required by subsection (I)(2) is included on the tag.

5. An employer shall ensure that the tag or copy of the citation attached to movable equipment is not altered, defaced, or physically covered by other material.
6. An employer shall ensure that the tag or copy of the citation attached to movable equipment remains attached until:
   a. The employer has abated the violation and all abatement verification documents required by this Section have been submitted to the Division;
   b. The employer has permanently removed the cited equipment from service or the cited equipment is no longer within the employer's control; or
   c. The Division, administrative law judge, or Review Board vacates the citation.

Appendix A-Sample Abatement-Certification Letter (Nonmandatory)

[Name], Director
The Industrial Commission of Arizona
Division of Occupational Safety and Health
P. O. Box 19070
Phoenix, Arizona 85005

[Company's Name]
[Company's Address]
The hazard referenced in Inspection Number [Insert 9-digit #] for violation identified as:
Citation [insert #] and item [insert #] was corrected on [insert date] by:
_____
_____.
Citation [insert #] and item [insert #] was corrected on [insert date] by:
_____
_____.
Citation [insert #] and item [insert #] was corrected on [insert date] by:
_____
_____.
Citation [insert #] and item [insert #] was corrected on [insert date] by:
_____
_____.
Citation [insert #] and item [insert #] was corrected on [insert date] by:
_____
_____.
I attest that the information contained in this document is accurate.

_____
Signature

_____
Typed or Printed Name

Appendix B-Sample Abatement Plan or Progress Report (Nonmandatory)

(Name), Director
The Industrial Commission of Arizona
Division of Occupational Safety and Health
P. O. Box 19070
Phoenix, Arizona 85005

[Company's Name]
[Company's Address]

Check one:
Abatement Plan [ ]
Progress Report [ ]

Inspection Number _____
Page _____ of _____
Citation Number(s)* _____
Item Number(s)* _____

Action	Proposed Completion Date (for abatement plans only)	Completion Date (for progress reports only)
1.	.....	.....
2.	.....	.....
3.	.....	.....
4.	.....	.....
5.	.....	.....

Date required for final abatement: _____
I attest that the information contained in this document is accurate.

_____
Signature

_____
Typed or Printed Name

Name of primary point of contact for questions: (optional)
Telephone number: _____

*Abatement plans or progress reports for more than one citation item may be combined in a single abatement plan or progress report if the abatement actions, proposed completion dates, and actual completion dates (for progress reports only) are the same for each of the citation items.

Appendix C-Sample Warning Tag (Nonmandatory)

O

WARNING:

EQUIPMENT HAZARD BY ADOSH

EQUIPMENT CITED:

_____
_____
_____

HAZARD CITED:

_____
_____
_____

FOR DETAILED INFORMATION
SEE ADOSH CITATION POSTED AT:

_____
_____

BACKGROUND COLOR--ORANGE
MESSAGE COLOR--BLACK

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, BANKING AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

PREAMBLE

1. **Sections Affected** — **Rulemaking Action**

Sections Affected	Rulemaking Action
R20-6-1105	Amend
R20-6-1106	Amend
R20-6-1110	Amend
R20-6-1113	Amend
Appendix B	Amend
Appendix F	Amend

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

   Authorizing statute: A.R.S. §20-143, 20-1133; 42 U.S.C. 1395

   Implementing statutes: A.R.S. §§ 41-1133; 42 U.S.C. 1395

3. **The effective date of the rules:**

   June 15, 1998

4. **A list of previous notices appearing in the Register addressing the final rule:**

   Notice of Docket Opening: 4 A.A.R. 476, February 13, 1998.

   Notice of Proposed Rulemaking: 4 A.A.R. 88, January 9, 1998.

   Notice of Proposed Rulemaking: 4 A.A.R. 407, February 13, 1998.

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

   Name: Gregory Y. Harris

   Address: Arizona Department of Insurance
   2910 N. 44th Street, Suite 210
   Phoenix, Arizona 85018

   Telephone: (602) 912-8456

   Fax: (602) 912-8452

6. **An explanation of the rule, including the agency's reasons for initiating the rule:**

   Medicare Supplement insurance is regulated by the state based on minimum standards prescribed by federal law. These changes reflect changes to federal law prescribed pursuant to the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. Subtitle A, Parts 144 and 146), and technical corrections previously requested by the Governor's Regulatory Review Council. Without the changes mandated by federal law, Medicare supplement insurance policies may not be sold in Arizona, except as directly regulated by the Federal Department of Health and Human Services/ Health Care Financing Administration (DHHS/ HCFA).

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**

   Not applicable.

8. **The summary of the economic, small business, and consumer impact:**

   These amendments are required by federal law of all issuers of Medicare supplement insurance. Any costs associated with these amendments is the result of federal law and not the result of adoption of these amendments. The technical corrections requested by the Governor's Regulatory Review Committee involve reformatting the rules and do not add new requirements for insurers.

9. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**

   The Office of the Secretary of State requested that changes to the proposed rulemaking packet the Department submitted be made in the final rulemaking. Accordingly, the Department has incorporated those changes into its final rules.

10. **A summary of the principal comments and agency response to them:**

    The Department did not receive any comments either in support of or in opposition to the proposed rule revisions.

11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**

    Not applicable.

12. **Incorporations by reference and their location in the rules:**

    Not applicable.

13. Was this rule previously adopted as an emergency rule?
Not applicable.

14. The full text of the rule follows:

TITLE 20. COMMERCE, PROFESSIONS, AND OCCUPATIONS

CHAPTER 6. DEPARTMENT OF INSURANCE

Section
R20-6-1105. Benefit Standards for Policies or Certificates Issued or Delivered on or After April 1, 1992
R20-6-1106. Standard Medicare Supplement Benefit Plans
R20-6-1110. Loss Ratio Standards and Refund or Credit of Premium
R20-6-1113. Required Disclosure Provisions
Appendix B. MEDICARE SUPPLEMENT COVERAGE PLANS
Appendix F. MEDICARE ~~DUPLICATION~~ DISCLOSURE STATEMENTS

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

R20-6-1105. Benefit Standards for Policies or Certificates Issued or Delivered on or After April 1, 1992

A. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after April 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.

B. General standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Article.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because the losses arise from 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 6 months before the effective date of coverage.
2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness different from ~~on a different basis than~~ losses resulting from accidents.
3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with these changes.
4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.
5. Each Medicare supplement policy shall be guaranteed renewable and the issuer:
   a. Shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and
   b. Shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.
6. If a Medicare supplement policy is terminated by a group policyholder and is not replaced as provided under subsection (B)(8), the issuer shall offer a certificate holder ~~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 subsection (B).
7. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:
   a. Offer the certificate holder the conversion opportunity described in subsection (B)(6); or
   b. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.
8. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the replaced ~~old~~ group policy on its date of termination. Coverage under the replacement group policy shall not exclude preexisting conditions that would have been covered under the group policy being replaced.
9. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that 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.
10. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period, not to exceed 24 months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to the medical assistance.
    a. If benefits and premiums are suspended under subsection (B)(10), and if the policyholder or certificate holder loses entitlement to medical assistance under Title XIX of the Social Security Act, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of the entitlement, if the policyholder or certificate holder provides notice of loss of the entitlement within 90

days after the date of the loss of the entitlement and pays the premium attributable to the period beginning when the entitlement to the medical assistance ended.

b. Reinstitution of coverage under subsection (B)(10)(a):

i. Shall not provide for any waiting period with respect to treatment of preexisting conditions.~~;~~

ii. Shall provide for coverage that is substantially equivalent to coverage in effect before the date of the suspension.~~;~~ and

iii. Shall 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.

C. Standards for basic "core" benefits common to all benefit plans. ~~1.~~ Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not instead of the basic "core" package. The "core" package consists of:

1. ~~a.~~ Coverage of Part A Medicare-eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

2. ~~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;

3. ~~c.~~ Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A-eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

4. ~~d.~~ Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells, unless replaced; and

5. ~~e.~~ Coverage for the coinsurance amount of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

D. Standards for additional benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by R20-6-1106:

~~1. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by R20-6-1106.~~

1. ~~a.~~ Medicare Part A deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period;

2. ~~b.~~ Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;

3. ~~c.~~ Medicare Part B deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

4. ~~d.~~ Eighty percent of the Medicare Part B excess charges: Coverage for 80% 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;

5. ~~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;

6. ~~f.~~ Basic outpatient prescription drug benefit: Coverage for 50% of outpatient prescription drug charges, after a $250 calendar-year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare;

7. ~~g.~~ Extended outpatient prescription drug benefit: Coverage for 50% of outpatient prescription drug charges, after a $250 calendar-year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare;

8. ~~h.~~ Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, that would have been covered by Medicare if provided in the United States and that began during the 1st 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset;

9. ~~i.~~ Preventive medical care benefit: Coverage for the following preventive health services:

a. ~~i.~~ An annual clinical preventive medical history and physical examination that may include tests and services described in subsection (D)(9)(b) ~~subdivision (ii) of this subparagraph~~ and patient education to address preventive health care measures;

b. ~~ii.~~ Any 1 or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

i. ~~(1)~~Fecal occult blood test or digital rectal examination, or both;

ii. ~~(2)~~Mammogram;

iii. ~~(3)~~Dipstick urinalysis for hematuria, bacteriuria and proteinuria ~~proteinauria~~;

iv. ~~(4)~~Pure tone, air only, hearing screening test, administered or ordered by a physician;

v. ~~(5)~~Serum cholesterol screening every 5 years;

vi. ~~(6)~~Thyroid function test; and

vii. ~~(7)~~Diabetes screening;

c. ~~iii.~~ Influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster every 10 years;

d. ~~iv.~~ Any other tests or preventive measures determined appropriate by the attending physician; and

e. ~~v.~~ Reimbursement shall be for the actual charges up to 100% 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 (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare;

10. ~~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,
    a. ~~i.~~ Coverage requirements; ~~and limitations~~
       i. ~~(1)~~ At-home recovery services provided must be primarily services that assist in activities of daily living; and
       ii. ~~(2)~~ 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 is ~~was~~ approved by Medicare;
    b. ~~(3)~~ Coverage is limited to:
       i. ~~(a)~~ 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 shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment~~,~~;
       ii. ~~(b)~~ The actual charges for each visit to a maximum reimbursement of $40 per visit~~,~~;
       iii. ~~(c)~~ $1,600 per calendar year~~,~~;
       iv. ~~(d)~~ 7 visits in any 1 week~~,~~;
       v. ~~(e)~~ Care furnished on a visiting basis in the insured's home~~,~~;
       vi. ~~(f)~~ Services provided by a care provider as defined in R20-6-1102 (4)~~,~~;
       vii. ~~(g)~~ At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded~~,~~; and
       viii. ~~(h)~~ At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than 8 weeks after the service date of the last Medicare-approved home health care visit.
    c. ~~(4)~~ Coverage is excluded for:
       i. ~~(a)~~ Home care visits paid for by Medicare or other government programs; and
       ii. ~~(b)~~ Care provided by family members, unpaid volunteers, or providers who are not care providers; and

11. ~~k.~~ New ~~or innovative~~ benefits: An issuer may, with the prior approval of the Director, offer policies or certificates with new or innovative benefits that do not violate any provision of Title 20, A.R.S., or otherwise conflict with this Article and are in addition to the benefits provided in a policy or certificate that otherwise comply 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 that is consistent with the goal of simplification of Medicare supplement policies.

R20-6-1106. Standard Medicare Supplement Benefit Plans

A. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core ~~"core"~~ benefits, as described in ~~A.A.C.~~ R20-6-1105(C).

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in R20-6-1105(D)(11) ~~A.A.C. R20-6-1105(D)(2)(k)~~ and in ~~A.A.C.~~ R20-6-1107.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this rule and conform to the definitions in R20-6-1103. Each benefit shall be structured in accordance with the format and sequence provided in R20-6-1105(C) and (D) ~~and list the benefits in the order shown in this subsection.~~ For purposes of this Section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. An issuer may use other designations, in addition to the benefit plan designations required in subsection (C) of this rule.

E. Format ~~Make-up~~ of benefit plans:

1. Standardized ~~Standardization~~ Medicare supplement benefit plan "A" shall be limited to the basic "core" benefits common to all benefit plans, as described in R20-6-1105(C).
2. Standardized ~~Standardization~~ Medicare supplement benefit plan "B" shall include only the following: The core benefits ~~benefit~~ as described in R20-6-1105(C~~) of this Article~~, plus the Medicare Part A deductible as described in R20-6-1105(D)(1)~~(a)~~.
3. Standardized ~~Standardization~~ Medicare supplement benefit plan "C" shall include only the following: The core benefits ~~benefit~~ as described in R20-6-1105(C) ~~of this Article~~, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as described in R20-6-1105(D)(1) through (3), and R20-6-1105(D)(1)(8) ~~R20-6-1105(D)(1)(a), (b), (c) and (h)~~ respectively.
4. Standardized ~~Standardization~~ Medicare supplement benefit plan "D" shall include only the following: The core benefits ~~benefit~~ as described in R20-6-1105(C~~) of this Article~~, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and ~~the~~ at-home recovery benefits ~~benefit~~ as described in R20-6-1105(D)(1) and (2), R20-6-1105(8), and R20-6-1105(10) ~~R20-6-1105(D)(1)(a), (b), (h) and (j)~~ respectively.
5. Standardized ~~Standardization~~ Medicare supplement benefit plan "E" shall include only the following: The core benefits ~~benefit~~ as described in R20-6-1105(C~~) of this Article~~, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the preventive medical care as defined in R20-6-1105(D)(1) and (2), R20-6-1105(D)(1)(8) and (9) ~~R20-6-1105(D)(1)(a), (b), (h) and (i)~~ respectively.
6. Standardized ~~Standardization~~ Medicare supplement benefit plan "F" shall include only the following: The core benefits ~~benefit~~ as described in R20-6-1105(C~~) of this Article~~, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% ~~percent~~ of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as described in R20-6-1105(D)(1) through (3), R20-6-1105(D)(5), and R20-6-1105(D)(8) ~~R20-6-1105(D)(1)(a), (b), (c), (e) and (h)~~ respectively.
7. Standardized ~~Standardization~~ Medicare supplement benefit plan "G" shall include only the following: The core benefit as described in R20-6-1105(C) of this Arti-

cle, plus the Medicare Part A deductible, skilled nursing facility care, 80% ~~percent~~ of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and ~~the~~ at-home recovery benefit as described in R20-6-1105(D)(1), (2), (4), (8), and (10) ~~R20-6-1105(D)(1)(a), (b), (d), (h) and (j)~~ respectively.

8. Standardized ~~Standardization~~ Medicare supplement benefit plan "H" shall include only the following: The core benefit as described in R20-6-1105(C) of this Article, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as described in R20-6-1105(D)(1), (2), (6), and (8) ~~R20-6-1105(D)(1)(a), (b), (f) and (h)~~ respectively.
9. Standardized ~~Standardization~~ Medicare supplement benefit plan "I" shall include only the following: The core benefit as described in R20-6-1105(C) of this Article, plus the Medicare Part A deductible, skilled nursing facility care, 100% ~~percent~~ of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefits as defined in R20-6-1105(D)(1), (2), (5), (6), (8), and (10) ~~R20-6-1105(D)(1)(a), (b), (e), (f), (h) and (j)~~ respectively.
10. Standardized ~~Standardization~~ Medicare supplement benefit plan "J" shall include only the following: The core benefit as described in R20-6-1105(C) of this Article, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100% ~~percent~~ of the Medicare Part B excess charges, extended basic prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as described in R20-6-1105(D)(1), (2), (3), (5), (7), (8), (9), and (10) ~~R20-6-1105(D)(1)(a), (b), (c), (e), (g), (h), (i) and (j)~~ respectively.

R20-6-1110. Loss Ratio Standards and Refund or Credit of Premium

A. Loss ratio standards.
   1. A Medicare supplement policy or certificate form shall not be delivered or issued for delivery unless the policy 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 or certificate:
      a. At least 75% of the aggregate amount of premiums earned in the case of group policies; ~~,~~ or
      b. At least 65% of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses if coverage is provided by a health care services organization on a service rather than reimbursement basis, and earned premiums for the period and in accordance with accepted actuarial principles and practices.
   2. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this Section ~~rule~~ when combined with actual experience to date. Filings of rate revisions shall 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.
   3. For policies issued before December 18, 1991, expected claims in relation to premiums shall meet:
      a. The originally filed anticipated loss ratio when combined with the actual experience since inception;
      b. The appropriate loss ratio requirement from subsection (A)(1) when combined with the actual experience beginning on ~~with~~ April 28, 1996, to date; and
      c. The appropriate loss ratio requirement from subsection (A)(1) over the entire future period for which the rates are computed to provide coverage.

B. Refund or credit calculation.
   1. An issuer shall collect and file with the Director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.
   2. If on the basis of the experience as reported, the benchmark ratio since inception exceeds the adjusted experience ratio since inception, a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies or certificates issued within the reporting year shall be excluded.
   3. For policies or certificates issued before December 18, 1991, the issuer shall make the refund or credit calculation separately for all individual policies combined and all group policies combined for experience after April 28, 1996. The issuer shall submit the 1st report under this subsection by May 31, 1998.
   4. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds .5% of the annualized premium in force as of December 31 of the reporting year. The refund or credit shall include interest from the end of the calendar year to the date of the refund or credit at a rate not less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual filing of premium rates.
   1. An issuer of Medicare supplement policies or certificates issued in this state before or after the effective date of this rule shall file annually by no later than January 1 its rates, rating schedule, and supporting documentation, including ratios of incurred losses to earned premiums, by policy duration for approval by the Director. The supporting documentation shall also demonstrate, in accordance with actuarial standards of practice using reasonable assumptions, that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected 3rd-year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than 3 years.
   2. Before the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the Director:
      a. Premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Supporting doc-

uments necessary to justify the adjustment shall accompany the filing.

i. An issuer shall make premium adjustments to produce an expected loss ratio under a policy or certificate that conforms with minimum loss ratio standards for Medicare supplement policies or certificates and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment that would modify the loss ratio experience under the policy or certificate other than the adjustments described in this subsection shall be made with respect to a policy or certificate at any time other than upon its renewal date or anniversary date.

ii. If an issuer fails to make premium adjustments in accordance with this Section ~~rule~~, the Director may order premium adjustments, refunds, or credits deemed necessary to achieve the loss ratio required by this Section ~~rule~~.

b. Any riders, endorsements, or policy forms needed to modify the Medicare supplement policy or certificate to eliminate benefit duplications with Medicare. The riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public hearings. The Director may conduct a public hearing ~~or hearings~~ to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this Section ~~rule~~ if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. The Director shall give notice of the hearing in accordance with A.R.S. § 20-163.

E. As used in this Section ~~rule~~, "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

R20-6-1113. Required Disclosure Provisions

A. General rules.

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the renewal or continuation provision shall be consistent with the type of contract issued. The provision shall be captioned as a renewal or continuation provision, shall appear on the 1st page of the policy or certificate, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's or certificate holder's age.

2. 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 the date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits or coverage are required by the minimum standards for Medicare supplement policies, or the increased benefits or coverage are ~~is~~ required by law. If a separate additional premium is charged for benefits or coverage provided in connection with riders or endorsements, the additional premium charge shall be set forth in the policy.

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

4. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations."

5. Medicare supplement policies and certificates shall have a notice prominently printed on or attached to the 1st page of the policy or certificate stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

6. Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense-incurred or indemnity basis, to a person eligible for Medicare shall provide to the applicant a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12-point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this Article. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request or, if not requested, no later than at the time the policy is delivered.

7. For the purposes of subsection (A)(6), "form" means language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice requirements.

1. As soon as practicable, but no later than 30 days before the annual effective date of any Medicare benefit change ~~changes~~, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates. The notice shall:

a. 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

b. Inform each policyholder and certificate holder when any premium adjustment is to be made due to changes in Medicare.

2. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms to facilitate comprehension.
3. The notices shall not contain or be accompanied by any solicitation.

C. Outline of coverage requirements for Medicare supplement policies.

1. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, issuers shall obtain an acknowledgment of receipt of the outline from the applicant.
2. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12- point type, immediately above the company name:
   "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."
3. The outline of coverage provided to applicants pursuant to this rule consists of 4 parts: a cover page, premium information, disclosure page ~~pages~~, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed in Appendix B in no less than 12-point type. The standard plans A-J shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and payment frequency shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.
4. The outline of coverage shall include the items in the order prescribed in Appendix B. The information contained in the outline of coverage shall be correct as of the date of its issuance and shall include amounts payable by Medicare, the insured's deductible and what the policy or certificate pays.

D. Notice regarding policies or certificates that are not Medicare supplement policies.

1. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy; a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. 1395 et seq.), disability income policy; or other policy identified in R20-6-1101(B), issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy or certificate that the policy or certificate is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the 1st page of the outline of coverage delivered to insureds under the policy or, if no outline of coverage is delivered, to the 1st page of the policy or certificate delivered to insureds. The notice shall be in not less than 12-point type and shall contain the following language:
   "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.
2. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subsection (D)(1) shall provide the applicable statement in Appendix F~~, the extent to which the policy duplicates Medicare~~. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

APPENDIX B

[12 point]

[COMPANY NAME]

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE - COVER PAGE:

BENEFIT PLAN(s) _____[insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only 10 standard plans. This chart shows the benefits included in each plan.

Every company must make available Plan "A". Some plans may not be available in your state.

BASIC BENEFITS: 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).

Blood: First 3 pints of blood each year.

A	B	C	D	E	F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	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%) ~~(100%)~~		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)	Basic Drugs ($1,250 Limit)
				Preventive Care					Preventive Care

APPENDIX B (CONT'D)

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 `The Medicare Handbook' for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [boldface type]

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

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

[Include for each plan prominently identified in the cover page a chart showing the services. Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than 4 plans may be shown on 1 chart. For purposes of illustration, charts for each plan are included in this Article. An issuer may use additional benefit plan designations on these charts pursuant to R20-6-1106.]

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

APPENDIX B (CONT'D)

PLAN A

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

* A benefit period begins on the 1st 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 $[764]~~628~~	$0	$[764]~~628~~ (Part A Deductible)
61st thru 90th day	All but $[191] ~~157~~ a day	$[191] ~~157~~ a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[382] ~~314~~a day	$[382] ~~314~~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 $[95.50] ~~78.50~~	$0	Up to $[95.50] ~~78.50~~ 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 outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CON'D)

PLAN A

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 * (the Part B Deductible)	$0	~~$[100]~~ $0	~~$0~~ $[100]
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] of Medicare-Approved Amounts *	$0	$0	$[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		
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%	20%	$0

APPENDIX B (CON'D)
PLAN B
MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the 1st 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 $[764]~~628~~	$[764]~~628~~ (Part A Deductible)	$0
61st thru 90th day	All but $[191]~~157~~ a day	$[191]~~157~~ a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[382]~~314~~ a day	$[382]~~314~~ 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 $[95.50]~~78.50~~	$0	Up to $[95.50] ~~78.50~~ 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 outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CON'D)
PLAN B
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 * (the Part B Deductible)	$0	$0	$[100]
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] of Medicare-Approved Amounts *	$0	$0	$[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		
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%	20%	$0

APPENDIX B (CONT'D)
PLAN C
MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the 1st 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 $[764]~~628~~	$[764]~~628~~ (Part A Deductible)	$0
61st thru 90th day	All but $[191]~~157~~ a day	$[191]~~157~~ a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[382]~~314~~ a day	$[382]~~314~~ 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 $[95.50]~~78.50~~ a day	Up to $[95.50]~~78.50~~ 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 outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN C
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	$[100] (the 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] of Medicare-Approved Amounts *	$0	$[100] (Part B Deductible)	$0 ~~(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		
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	$[100] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 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 $50,000 lifetime maximum

APPENDIX B (CONT'D)
PLAN D
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] (the 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] of Medicare-Approved Amounts *	$0	$0	$[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		
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%	20%	$0

APPENDIX B (CONT'D)

PLAN D

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 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 $50,000 lifetime maximum

APPENDIX B (CONT'D)
PLAN E
MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the 1st 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 $[764]~~628~~	$[764]~~628~~ (Part A Deductible)	$0
61st thru 90th day	All but $[191]~~157~~ a day	$[191]~~157~~ a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[382]~~314~~ a day	$[382]~~314~~ 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 $[95.50]~~78.50~~ a day	Up to $[95.50]~~78.50~~ 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 outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN E
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 * (the Part B Deductible)	$0	$0	$[100]
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] of Medicare-Approved Amounts *	$0	$[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		
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%	20%	$0

APPENDIX B (CONT'D)

PLAN E

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OTHER BENEFITS			
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE			
Annual physical and preventive tests and services, such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, 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
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 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 $50,000 lifetime maximum

APPENDIX B (CONT'D)
PLAN F
MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

* A benefit period begins on the 1st 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 $[764]~~628~~	$[764]~~628~~ (Part A Deductible)	$0
61st thru 90th day	All but $[191]~~157~~ a day	$[191]~~157~~ a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[382]~~314~~ a day	$[382]~~314~~ 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 $[95.50]~~78.50~~ a day	Up to $[95.50]~~78.50~~ 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 outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)

PLAN F

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	$[100] (the 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] of Medicare-Approved Amounts *	$0	$[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

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 Amount *	$0	$[100] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

OTHER BENEFITS

FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 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 $50,000 lifetime maximum

APPENDIX B (CONT'D)

PLAN G

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

* A benefit period begins on the 1st 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 $[764]~~628~~	$[764]~~628~~ (Part A Deductible)	$0
61st thru 90th day	All but $[191]~~157~~ a day	$[191]~~157~~ a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[382]~~314~~ a day	$[382]~~314~~ 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 $[95.50]~~78.50~~ a day	Up to $[95.50]~~78.50~~ 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 outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN G
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 * (the Part B Deductible)	$0	$0	$[100]
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] of Medicare-Approved Amounts *	$0	$0	$[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		
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%	20%	$0

APPENDIX B (CONT'D)

PLAN G

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 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 $50,000 lifetime maximum

APPENDIX B (CONT'D)
PLAN H
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the 1st 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 $[764]~~628~~	$[764]~~628~~ (Part A Deductible)	$0
61st thru 90th day	All but $[191]~~157~~ a day	$[191]~~157~~ a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[382]~~314~~ a day	$[382]~~314~~ 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 $[95.50]~~78.50~~ a day	Up to $[95.50]~~78.50~~ 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 outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN H
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 * (the Part B Deductible)	$0	$0	$[100]
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] of Medicare-Approved Amounts *	$0	$0	$[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		
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%	20%	$0

APPENDIX B (CONT'D)

PLAN H

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
	OTHER BENEFITS		
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
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 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 $50,000 lifetime maximum

APPENDIX B (CONT'D)
PLAN I
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the 1st 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 $[764]~~628~~	$[764]~~628~~ (Part A Deductible)	$0
61st thru 90th day	All but $[191]~~157~~ a day	$[191]~~157~~ a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[382]~~314~~ a day	$[382]~~314~~ 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 $[95.50]~~78.50~~ a day	Up to $[95.50]~~78.50~~ 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 outpatient drugs and inpatient respite care	$0	Balance

APPENDIX B (CONT'D)
PLAN I
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 * (the Part B Deductible)	$0	$0	$[100]
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] of Medicare-Approved Amounts *	$0	$0	$[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		
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%	20%	$0

APPENDIX B (CONT'D)
PLAN I
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 Medicare-Approved visits, not to exceed 7 each week	
- Calendar year maximum	$0	$1,600	
OTHER BENEFITS			
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
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 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 $50,000 lifetime maximum

APPENDIX B (CONT'D)
PLAN J
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the 1st 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 $[764]~~628~~	$[764]~~628~~ (Part A Deductible)	$0
61st thru 90th day	All but $[191]~~157~~ a day	$[191]~~157~~ a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[382]~~314~~ a day	$[382]~~314~~ 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 $[95.50]~~78.50~~ a day	Up to $[95.50]~~78.50~~ 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

APPENDIX B (CONT'D)
PLAN J
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 * (the Part B Deductible)	$0	$[100]	$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] of Medicare-Approved Amounts *	$0	$[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] of Medicare-Approved Amounts *	$0	$[100] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

APPENDIX B (CONT'D)
PLAN J
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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			
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 calendear year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All costs
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE			
Annual physical and preventive tests and services, such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, 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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OTHER BENEFITS (continued)			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 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 $50,000 lifetime maximum

Appendix F

MEDICARE ~~DUPLICATION~~ DISCLOSURE STATEMENTS

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

~~1. Federal law, P.L. 103-432, 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.~~

1. ~~2. All types of health insurance policies that duplicate Medicare shall include 1 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).

2. ~~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.

3. ~~4.~~ Property/Casualty and Life insurance policies are not considered health insurance.

4. ~~5.~~ Disability income policies are not considered to provide benefits that duplicate Medicare.

5. ~~6.~~ The federal law does not pre-empt state laws that are more stringent than the federal requirements.

6. ~~7.~~ The federal law does not pre-empt existing state form filing requirements.

[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 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 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
- 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 insurance counseling program.

[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 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.

~~**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
- 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 insurance counseling program.

[For policies that reimburse expenses incurred for specified disease(s) or other specified impairment(s). 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 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 hospital or medical expenses only when you are treated for 1 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
- 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 insurance counseling program.

[For policies that pay fixed dollar amounts for specified disease(s) or other specified impairment(s). 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

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

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for 1 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
- 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 insurance counseling program.

[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 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 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
- hospice
- 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 insurance counseling program.

[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 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 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
- 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 insurance counseling program.

[For long-term care policies providing both nursing home and non-institutional coverage.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

~~THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS~~

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

~~**This is not Medicare Supplement Insurance**~~

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

Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by ~~duplicates~~ Medicare ~~benefits in some situations~~.

- This is long-term care insurance that provides benefits for covered nursing home and home care services.
- In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most long-term care expenses.

Before You Buy This Insurance

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

√ For more information about long-term care insurance, review the *Shopper's Guide to Long-Term Care Insurance*, available from the insurance company.

√ 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 insurance counseling program.

[For long-term care policies providing nursing home benefits only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

~~THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS~~

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

~~**This is not Medicare Supplement Insurance**~~

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

Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by ~~duplicates~~ Medicare ~~benefits in some situations~~.

- This insurance provides benefits primarily for covered nursing home services.
- In some situations Medicare pays for short periods of skilled nursing home care and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most nursing home expenses.

Before You Buy This Insurance

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

√ For more information about long-term care insurance, review the *Shopper's Guide to Long-Term Care Insurance*, available from the insurance company.

√ 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 insurance counseling program.

[For policies providing home care benefits only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

~~THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS~~

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

~~**This is not Medicare Supplement Insurance**~~

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

Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by ~~duplicates~~ Medicare ~~benefits in some situations~~.

- This insurance provides benefits primarily for covered home care services.
- In some situations, Medicare will cover some health related services in your home and hospice care which may also be covered by this insurance.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most services in your home.

Before You Buy This Insurance

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

√ For more information about long-term care insurance, review the *Shopper's Guide to Long-Term Care Insurance*, available from the insurance company.

√ 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 insurance counseling program.

[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 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 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
- 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 insurance counseling program.