2/11/09

PROPOSED RULES

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

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45-06-01.1-01. Applicability and scope. – No amendments

45-06-01.1-02. Definitions. For purposes of this chapter:

1. "1990 standardized medicare supplement benefit plan," "1990 standardized benefit plan" or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after January 1, 1992, and prior to June 1, 2010, and includes medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

2. “2010 standardized medicare supplement benefit plan," "2010 standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare supplement insurance issued on or after June 1, 2010.

3. "Applicant" means:

   a. In the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits; and

   b. In the case of a group medicare supplement policy, the proposed certificate holder.

~~2.~~ 4. "Bankruptcy" means when a medicare advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

~~3.~~ 5. "Certificate" means any certificate delivered or issued for delivery in this state under a group medicare supplement policy.

~~4.~~ 6. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

~~5.~~ 7. "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of

the coverage the individual had no breaks in coverage greater than sixty-three days.

~~6.~~ 8. a. "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(1) A group health plan;

(2) Health insurance coverage;

(3) Part A or part B of title XVIII of the Social Security Act (medicare);

(4) Title XIX of the Social Security Act ~~(medicaid),~~ other than coverage consisting solely of benefits under section 1928;

(5) 10 U.S.C. 55 (CHAMPUS);

(6) A medical care program of the Indian health service or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under 5 U.S.C. 89 (federal employees health benefits program);

(9) A public health plan as defined in federal regulations; and

(10) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

b. "Creditable coverage" does not include one or more, or any combination of, the following:

(1) Coverage only for accident or disability income insurance, or any combination thereof;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for onsite medical clinics; and

(8) Other similar insurance coverage, specified in federal regulations under which benefits for medical care are secondary or incidental to other insurance benefits.

c. "Creditable coverage" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

(3) Such other similar, limited benefits as are specified in federal regulations.

d. "Creditable coverage" does not include the following benefits if offered as independent, noncoordinated benefits:

(1) Coverage only for a specified disease or illness; and

(2) Hospital indemnity or other fixed indemnity insurance.

e. "Creditable coverage" does not include the following if it is offered as a separate policy, certificate, or contract of insurance:

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

(2) Coverage supplemental to the coverage provided under 10 U.S.C. 55; and

(3) Similar supplemental coverage provided to coverage under a group health plan.

~~7.~~ 9. "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in 29 U.S.C. 1002 (Employee Retirement Income Security Act).

~~8.~~ 10. "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of:

a. Any capital and surplus required by law for its organization; or

b. The total par or stated value of its authorized and issued capital stock.

~~9.~~ 11. "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

~~10.~~ 12. "Medicare" means the Health Insurance for the Aged Act, title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

~~11.~~ 13. "Medicare advantage plan" means a plan of coverage for health benefits under medicare part C as defined in ~~[refer to definition of medicare advantage plan in~~ 42 U.S.C. 1395w-28(b)(1)~~],~~ and includes:

a. Coordinated care plans which provide health care services, including health maintenance organization plans, with or without a point-of-service option; plans offered by provider-sponsored organizations; and preferred provider organization plans;

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

c. Medicare advantage private fee-for-service plans.

~~12.~~ 14. "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under section 1876 of the federal Social Security Act [42 U.S.C. 1395 et seq.] or an issued policy under the demonstration project specified in 42 U.S.C. 1395ss(g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare. "Medicare supplement policy" does not include medicare advantage plans established under medicare part C, outpatient prescription drug plans established under medicare part D, or any health care prepayment plan that provides benefits pursuant to an agreement under section 1833(a)(1)(A) of the Social Security Act.

~~13.~~ 15. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

16. "Pre-standardized medicare supplement benefit plan," "pre-standardized benefit plan" or "pre-standardized plan" means a group or individual policy of medicare supplement insurance issued prior to January 1, 1992.

~~14.~~ 17. "Secretary" means the secretary of the United States department of health and human services.

History: Effective January 1, 1992; amended effective August 27, 1998; December 1, 2001; September 1, 2005;______.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1

45-06-01.1-03. Policy definitions and terms. – No amendments

45-06-01.1-04. Policy provisions.

1. Except for permitted preexisting condition clauses as described in subdivision a of subsection 1 of section 45-06-01.1-05 ~~and~~, subdivision a of subsection 1 of section 45-06-01.1-06, and subdivision 1 of subsection a of section 45-06-01.1-06.1, no policy or certificate may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of medicare.

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No amendments to remainder of Section 45-06-01.1-04.

History: Effective January 1, 1992; amended effective July 8, 1997; September 1, 2005;_________.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-05. Minimum benefit standards for pre-standardized medicare supplement benefit plan policies or certificates issued for delivery prior to January 1, 1992. No policy or certificate may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards:

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

   a. A medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

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

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

   d. A "noncancelable", "guaranteed renewable", or "noncancelable and guaranteed renewable" medicare supplement policy may not:

      (1) 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; or

      (2) Be canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

   e. (1) Except as authorized by the commissioner of this state, an issuer may neither cancel nor nonrenew a medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

      (2) If a group medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in paragraph 4, the issuer must offer certificate holders an individual medicare supplement policy. The issuer must offer the certificate holder at least the following choices:

(a) An individual medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group medicare supplement policy; and

(b) An individual medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in subsection 2 of section ~~45-06-01.1-06~~ 45-06-01.1-06.1.

(3) If membership in a group is terminated, the issuer must:

(a) Offer the certificate holder the conversion opportunities described in paragraph 2; or

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

(4) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy must offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

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

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

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No amendments to the remainder of Section 45-06-01.1-05.

History: Effective January 1, 1992; amended effective July 1, 1994; April 1, 1996; July 8, 1997; September 1, 2005;__________.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-06. Benefit standards for 1990 standardized medicare supplement benefit plan policies or certificates issued or delivered on or after January 1, 1992, and prior to June 1, 2010. The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state on or after January 1, 1992, and prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards:

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

   a. A medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

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

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

   d. No medicare supplement policy or certificate may provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

   e. Each medicare supplement policy must be guaranteed renewable:

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

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

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

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

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

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

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

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

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

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

deemed to satisfy the guaranteed renewal requirements of this paragraph.

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

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

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

(3) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for any period that may be provided by federal regulation at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be

automatically reinstituted, effective as of the date of loss of such coverage, if the policyholder provides notice of loss of coverage within ninety days after the date of such loss and pays the premium due from that date.

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

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

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

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

h. If an issuer makes a written offer to the medicare supplement policyholders or certificate holders of one or more of its plans, to exchange during a specified period from the 1990 standardized plan as described in section 45-06-01.1-07 to a 2010 standardized plan as described in section 45-06-01.1-07.1, the offer and subsequent exchange shall comply with the following requirements:

(a) An issuer need not provide justification to the commissioner if the insured replaces a 1990 standardized policy or certificate with an issue age rated 2010 standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the prefunding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the commissioner.

(b) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(c) An issuer may not apply new preexisting condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 standardized policy or certificate of the insured, but may apply preexisting condition limitations of no more than six months to any added benefits contained in the new 2010 standardized policy or certificate not contained in the exchanged policy.

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

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

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

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

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

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

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

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

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

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

i. (1) Preventive medical care benefit: Coverage for the following preventive health services not covered by medicare:

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

~~(2)~~ (b) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

(2) Reimbursement must be for the actual charges up to one hundred percent of the medicare-approved amount for each service, as if medicare were to cover the service as identified in American medical association current procedural terminology codes, to a maximum of one hundred twenty

dollars annually under this benefit. This benefit may not include payment for any procedure covered by medicare.

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

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

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

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

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

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

(2) Coverage requirements and limitations.

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

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

(c) Coverage is limited to:

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

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

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

[4] Seven visits in any one week.

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

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

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

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

(3) Coverage is excluded for:

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

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

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No amendments to remainder of Section 45-06-01.1-06.

History: Effective January 1, 1992; amended effective April 1, 1996; July 8, 1997; August 1, 2000; December 1, 2001; September 1, 2005; ______.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-06.1. Benefit standards for 2010 standardized medicare supplement benefit plan policies or certificates issued for delivery on or after June 1, 2010. The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 standardized medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of North Dakota Century Code chapter 26.1-36.1.

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

   a. A medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

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

   c. 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, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

   d. 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.

e. Each Medicare supplement policy shall be guaranteed renewable.

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

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

(3) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under paragraph 5, the issuer shall offer certificate holders an individual medicare supplement policy which at the option of the certificate holder:

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

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

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

(a) Offer the certificate holder the conversion opportunity described in paragraph 3; or

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

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

f. Termination of a medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the

maximum benefits. Receipt of medicare part D benefits will not be considered in determining a continuous loss.

g. (1) A medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period not to exceed twenty-four months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety days after the date the individual becomes entitled to assistance. Upon receipt of timely notice, the issuer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of medical assistance eligibility subject to adjustment for paid claims.

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

(3) Each medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for any period that may be provided by federal regulation at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within ninety days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

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

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

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

(c) 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.

2. Standards for basic benefits common to medicare supplement insurance benefit plans A, B, C, D, F, F with high deductible, G, M and N. Every issuer of medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic core package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other medicare supplement insurance benefit plans in addition to the basic core package but not in lieu of it.

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

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

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

d. Coverage under medicare parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, unless replaced in accordance with federal regulations;

e. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of medicare eligible expenses under part B regardless of hospital confinement, subject to the medicare part B deductible;

f. Hospice care. Coverage of cost sharing for all part A medicare eligible hospice care and respite care expenses.

3. Standards for additional benefits. The following additional benefits shall be included in medicare supplement benefit plans B, C, D, F, F with high deductible, G, M, and N as provided by section 45-06-01.1-07.1.

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

b. Medicare part A deductible: Coverage for fifty percent of the medicare part A inpatient hospital deductible amount per benefit period.

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

d. Medicare part B deductible: Coverage for one hundred percent of the medicare part B deductible amount per calendar year regardless of hospital confinement.

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

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

care needed immediately because of an injury or an illness of sudden and unexpected onset.

History: Effective __________.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-07. Standard medicare supplement benefit plans for 1990 standardized medicare supplement benefit plan policies or certificates issued for delivery on or after January 1, 1992, and prior to June 1, 2010.

. . .

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

. . .

No amendments to remainder of Section 45-06-01.1-07.

History: Effective January 1, 1992; amended effective July 1, 1994; August 27, 1998; September 1, 2005; __________.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-07.1. Standard medicare supplement benefit plans for 2010 standardized medicare supplement benefit plan policies or certificates issued for delivery on or after June 1, 2010. The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of North Dakota Century Code chapter 26.1-36.1.

1. a. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the

basic benefits, as defined in subsection 2 of section 45-06-01.1-06.1.

b. If an issuer makes available any of the additional benefits described in subsection 3 of section 45-06-01.1-06.1, or offers standardized benefit plans K or L as described in subdivisions h and i of subsection 5, then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic benefits as described in subdivision a, a policy form or certificate form containing either standardized benefit plan C as described in subdivision c of subsection 5 or standardized benefit plan F as described in subdivision e of subsection 5.

2. No groups, packages or combinations of medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in subsection 6 and section 45-06-01.1-08.

3. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this subsection and conform to the definitions in section 45-06-01.1-02. Each benefit shall be structured in accordance with the format provided in subsections 2 and 3 of section 45-06-01.1-06.1; or, in the case of plans K or L, in subdivisions h and i of subsection 5 and list the benefits in the order shown. For purposes of this section, “structure, language, and format” means style, arrangement and overall content of a benefit.

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

5. Make-up of 2010 standardized benefit plans:

a. Standardized medicare supplement benefit plan A shall include only the following: The basic benefits as defined in subsection 2 of section 45-06-01.1-06.1.

b. Standardized medicare supplement benefit plan B shall include only the following: The basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the medicare part A deductible as defined in subdivision a of subsection 3 of section 45-06-01.1-06.1.

c. Standardized medicare supplement benefit plan C shall include only the following: The basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the medicare part A deductible, skilled nursing facility care, one hundred percent

of the medicare part B deductible, and medically necessary emergency care in a foreign country as defined in subdivisions a, c, d, and f of subsection 3 of section 45-06-01.1-06.1, respectively.

d. Standardized medicare supplement benefit plan D shall include only the following: The basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in an foreign country as defined in subdivisions a, c, and f of subsection 3 of section 45-06-01.1-06.1, respectively.

e. Standardized medicare supplement Plan F shall include only the following: The basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the medicare part A deductible, the skilled nursing facility care, one hundred percent of the medicare part B deductible, one hundred percent of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in subdivisions a, c, d, e, and f of subsection 3 of section 45-06-01.1-06.1, respectively.

f. Standardized medicare supplement plan F with high deductible shall include only the following: one hundred percent of covered expenses following the payment of the annual deductible set forth in paragraph 2.

(1) The basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the medicare part A deductible, skilled nursing facility care, one hundred percent of the medicare part B deductible, one hundred percent of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in subdivisions a, c, d, e, and f of subsection 3 of section 45-06-01.1-06.1, respectively.

(2) The annual deductible in plan F with high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be one thousand five hundred dollars and shall be adjusted annually from 1999 by the secretary of the United States department of health and human services to reflect the change in the consumer price index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

g. Standardized medicare supplement benefit plan G shall include only the following: The basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the medicare part A deductible, skilled nursing facility care, one hundred percent of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in subdivisions a, c, e, and f of subsection 3 of section 45-06-01.1-06.1, respectively.

h. Standardized medicare supplement plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

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

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

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

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

(5) Skilled nursing facility care: Coverage for fifty percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a medicare benefit period for post-hospital skilled nursing facility care eligible

under medicare part A until the out-of-pocket limitation is met as described in paragraph 10;

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

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

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

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

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

i. Standardized medicare supplement plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(1) The benefits described in paragraphs 1, 2, 3, and 8 of subdivision h of subsection 5 of section 45-06-01.1-07.1;

(2) The benefit described in paragraphs 4, 5, 6, 7, and 8 of subdivision h of subsection 5 of section 45-06-01.1-07.1, but substituting seventy-five percent for fifty percent; and

(3) The benefit described in paragraph 10 of subdivision h of subsection 5 of section 45-06-01.1-07.1, but substituting two thousand dollars for four thousand dollars.

j. Standardized medicare supplement plan M shall include only the following: The basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus fifty percent of the medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in subdivisions b, c, f of subsection 3 of section 45-06-01.1-06.1, respectively.

k. Standardized medicare supplement plan N shall include only the following: The basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in subdivisions a, c, and f of subsection 3 of section 45-06-01.1-06.1, respectively, with copayments in the following amounts:

(1) The lesser of twenty dollars or the medicare part B coinsurance or copayment for each covered health care provider office visit including visits to medical specialists; and

(2) The lesser of fifty dollars or the medicare part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a medicare part A expense.

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

History: Effective ___________.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-08. Medicare select policies and certificates. – No amendments

45-06-01.1-09. Open enrollment. – No amendments

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

. . .

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

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

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

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

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

        (3) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act, if the individual has not paid premiums on a

timely basis or has engaged in disruptive behavior as specified in standards under section 1856, or the plan is terminated for all individuals within a residence area;

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

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

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

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

c. (1) The individual is enrolled with:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

. . .

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

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

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

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

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

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

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

   d. Subdivision g of subsection 2 is a medicare supplement policy that has a benefit package classified as plan A, B, C, F (including F with a high deductible), K, or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's medicare supplement policy with outpatient prescription drug coverage.

. . .

No amendments to remainder of Section 45-06-01.1-09.

History: Effective August 27, 1998; amended effective December 1, 2001; September 1, 2005;__________.
General Authority: NDCC 26.1-36.1-02, 26.1-36.1-03

Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-10. Standards for claims payment. – No amendments

45-06-01.1-11. Loss ratio standards and refund or credit of premium. – No amendments

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

. . .

7. An issuer shall not present for filing or approval a rate structure for its medicare supplement policies or certificates issued after the effective date of the amendment of this chapter based upon a structure or methodology with any groupings of attained ages greater than one year. The ratio between rates for successive ages shall increase smoothly as age increases.

History: Effective January 1, 1992; amended effective July 1, 1994; September 1, 2005;____________.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-13. Permitted compensation arrangements. – No amendments

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

. . .

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

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

   b. If an outline of coverage is provided at the time of application and the medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must

accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve-point type, immediately above the company name:

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

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

d. The following items must be included in the outline of coverage in the order prescribed below:

**[Replace the Outline of Coverage chart (4 pages)
with the new Outline of Coverage (1 page).
New Outline of Coverage chart is on following page.]**

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

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

Plans E, H, I, and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]

Basic Benefits:

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

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

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

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

PREMIUM INFORMATION [Boldface Type]

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

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

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

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

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

RIGHT TO RETURN POLICY [Boldface Type]

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

POLICY REPLACEMENT [Boldface Type]

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

NOTICE [Boldface Type]

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

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

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

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

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

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to subsection 4 of Section ~~45-06-01.1-07~~ 45-06-01.1-07.1.]

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~[$876]~~ $[1068]	$0	~~[$876]~~ $[1068] (Part A deductible)
61st thru 90th day	All but ~~[$219]~~ $[267] a day	~~[$219]~~ $[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but ~~[$438]~~ $[534] a day	~~[$438]~~ $[534] a day	$0
—Once lifetime reserve days are used:		100% of Medicare eligible expenses	$0**
—Additional 365 days	$0	$0	All costs
—Beyond the additional 365 days	$0		
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~[$109.50]~~ $[133.50] a day	$0	Up to ~~[$109.50]~~ $[133.50] a day
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE ~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services.~~ You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited ~~coinsurance~~ copayment/ coinsurance for out-patient drugs and inpatient respite care	~~$0~~ Medicare copayment/ coinsurance	~~Balance~~ $0

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

PLAN A

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

* Once you have been billed ~~[$100]~~ $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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]~~ $[135] of Medicare-Approved Amounts*	$0	$0	~~[$100]~~ $[135] (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]~~ $[135] of Medicare Approved Amounts*	$0	$0	~~[$100]~~ $[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~[$876]~~ $[1068]	~~[$876]~~ $[1068] (Part A deductible)	$0
61st thru 90th day	All but ~~[$219]~~ $[267] a day	~~$[219]~~ $[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but ~~[$438]~~ $[534] a day	~~[$438]~~ $[534] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~[$109.50]~~ $[133.50] a day	$0	Up to ~~[$109.50]~~ $[133.50] a day
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE ~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~ You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited ~~coinsurance~~ copayment/ coinsurance for out-patient drugs and inpatient respite care	~~$0~~ Medicare copayment/ coinsurance	~~Balance~~ $0

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

PLAN B

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

* Once you have been billed ~~[$100]~~ $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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]~~ $[135] of Medicare Approved Amounts*	$0	$0	~~[$100]~~ $[135] (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]~~ $[135] of Medicare Approved Amounts*	$0	$0	~~[$100]~~ $[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~[$876]~~ $[1068]	~~[$876]~~ $[1068] (Part A deductible)	$0
61st thru 90th day	All but ~~[$219]~~ $[267] a day	~~[$219]~~ $[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but ~~[$438]~~ $[534] a day	~~[$438]~~ $[534] a day	$0
—Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~[$109.50]~~ $[133.50] a day	Up to ~~[$109.50]~~ $[133.50] a day	$0
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE ~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services.~~ You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited ~~coinsurance~~ copayment/ coinsurance for out-patient drugs and inpatient respite care	~~$0~~ Medicare copayment/ Coinsurance	~~Balance~~ $0

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

PLAN C

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

* Once you have been billed ~~[$100]~~ $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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]~~ $[135] of Medicare Approved Amounts*	$0	~~[$100]~~ $[135] (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]~~ $[135] of Medicare Approved Amounts*	$0	~~[$100]~~ $[135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~[$876]~~ $[1068]	~~[$876]~~ $[1068] (Part A deductible)	$0
61st thru 90th day	All but ~~[$219]~~ $[267] a day	~~[$219]~~ $[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but ~~[$438]~~ $[534] a day	~~[$438]~~ $[534] a day $0	$0
—Once lifetime reserve days are used:	$0	100% of Medicare eligible expenses	$0**
Additional 365 days —Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~[$109.50]~~ $[133.50] a day	Up to ~~[$109.50]~~ $[133.50] a day	$0
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE ~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~ You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited ~~coinsurance~~ copayment/ coinsurance for out-patient drugs and inpatient respite care	~~$0~~ Medicare copayment/ coinsurance	~~Balance~~ $0

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

PLAN D

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

* Once you have been billed ~~[$100]~~ $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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]~~ $[135] of Medicare Approved Amounts*	$0	$0	~~[$100]~~ $[135] (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]~~ $[135] of Medicare Approved Amounts*	$0	$0	~~[$100]~~ $[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	$0	$0
First ~~[$100]~~ $[135] of Medicare Approved Amounts*	$0	$0	~~[$100]~~ $[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
~~AT-HOME RECOVERY SERVICES–NOT COVERED BY MEDICARE~~			
~~Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan~~			
~~–Benefit for each visit~~	~~$0~~	~~Actual charges to $40 a visit~~	~~Balance~~
~~–Number of visits covered (Must be received within 8 weeks of last Medicare-approved visit)~~	~~$0~~	~~Up to the number of Medicare-approved visits, not to exceed 7 each week~~	
~~–Calendar year maximum~~	~~$0~~	~~$1,600~~	

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN E
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR
PARTS A & B
OTHER BENEFITS – NOT COVERED BY MEDICARE

DELETED

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

[This high deductible plan pays the same benefits as Plan F after one has paid a calendar year ~~[$1,690]~~ [$2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are ~~[$1,690]~~ [$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY ~~[$1,690]~~ $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO ~~[$1,690]~~ $[2000] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~[$876]~~ $[1068]	~~[$876]~~ $[1068] (Part A deductible)	$0
61st thru 90th day	All but ~~[$219]~~ $[267] a day	~~[$219]~~ $[267] a day	$0
91st day and after: —While using 60 Lifetime reserve days	All but ~~[$438]~~ $[534] a day	~~[$438]~~ $[534] a day	$0
Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	[AFTER YOU PAY ~~[$1690]~~ $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
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 $[133.50] a day	Up to ~~[$109.50]~~ $[133.50] 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.~~ You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited ~~coinsurance~~ copayment/ coinsurance for out-patient drugs and inpatient respite care	~~$0~~ Medicare copayment/ coinsurance	~~Balance~~ $0

(continued)

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed ~~[$100]~~ $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[This high deductible plan pays the same benefits as Plan F after one has paid a calendar year ~~[$1690]~~ [$2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are ~~[$1690]~~ [$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY ~~[$1690]~~ $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO ~~[$1690]~~ $[2000] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician's Services, inpatient and Outpatient medical and Surgical services and Supplies, physical and Speech therapy, Diagnostic tests, Durable medical Equipment,			
First ~~[$100]~~ $[135] of Medicare Approved amounts*	$0	~~[$100]~~ $[135] (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]~~ $[135] of Medicare Approved amounts*	$0	~~[$100]~~ $[135] (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0

SERVICES	MEDICARE PAYS	[AFTER YOU PAY ~~[$1690]~~ $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO ~~[$1690]~~ $[2000] DEDUCTIBLE,**] YOU PAY
CLINICAL LABORATORY SERVICES—-TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~[$1690]~~ $[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~[$1690]~~ $[2000] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	$0	$0
First ~~[$100]~~ $[135] of Medicare Approved Amounts*	$0	~~[$100]~~ $[135] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~[$1690]~~ $[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~[$1690]~~ $[2000] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~[$876]~~ $[1068]	~~[$876]~~ $[1068] (Part A deductible)	$0
61st thru 90th day	All but ~~[$219]~~ $[267] a day	~~[$219]~~ $[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but ~~[$438]~~ $[534] a day	~~[$438]~~ $[534] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~[$109.50]~~ $[133.50] a day	Up to ~~[$109.50]~~ $[133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE ~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services.~~ You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited ~~coinsurance~~ copayment/ coinsurance for out-patient drugs and inpatient respite care	~~$0~~ Medicare copayment/ coinsurance	~~Balance~~ $0

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

PLAN G

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

* Once you have been billed ~~[$100]~~ $[133.50] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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]~~ $[135] of Medicare Approved Amounts*	$0	$0	~~[$100]~~ $[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	~~20%~~ $0
BLOOD First 3 pints	$0	All costs	$0
Next ~~[$100]~~ $[135] of Medicare Approved Amounts*	$0	$0	~~[$100]~~ $[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	$0	$0
First ~~[$100]~~ $[135] of Medicare Approved Amounts*	$0	$0	~~[$100]~~ $[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
~~AT-HOME RECOVERY SERVICES–NOT COVERED BY MEDICARE~~			
~~Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan~~			
~~–Benefit for each visit~~	~~$0~~	~~Actual charges to $40 a visit~~	~~Balance~~
~~–Number of visits covered (Must be received within 8 weeks of last Medicare-approved visit)~~	~~$0~~	~~Up to the number of Medicare-approved visits, not to exceed 7 each week~~	
~~–Calendar year maximum~~	~~$0~~	~~$1,600~~	

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN H
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR
PARTS A & B
OTHER BENEFITS – NOT COVERED BY MEDICARE

DELETE

PLAN I
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR
PARTS A & B
OTHER BENEFITS – NOT COVERED BY MEDICARE

DELETE

PLAN J or HIGH DEDUCTIBLE PLAN
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR
PARTS A & B
OTHER BENEFITS – NOT COVERED BY MEDICARE

DELETE

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of ~~[$4000]~~ $[4620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare co-payment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~[$876]~~ $[1068]	~~[$438]~~ $[534] (50% of Part A deductible)	~~[$438]~~ $[534] (50% of Part A deductible)♦
61st thru 90th day	All but ~~[$219]~~ $[267] a day	~~[$219]~~ $[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but ~~]$438]~~ $[534] a day	~~[$438]~~ $[534] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital First 20 days	All approved amounts.	$0	$0
21st thru 100th day	All but ~~[$109.50]~~ $[133.50] a day	Up to ~~[$54.75]~~ $[66.75] a day	Up to ~~[$54.75]~~ $[66.75] a day ♦
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	50%	50%♦
Additional amounts	100%	$0	$0
HOSPICE CARE ~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services.~~ You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited ~~coinsurance~~ copayment/ coinsurance for outpatient drugs and inpatient respite care	50% of copayment/ coinsurance	50% of Medicare copayment/ coinsurance♦

(continued)

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

PLAN K

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

**** Once you have been billed ~~[$100]~~ $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
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]~~ $[135] of Medicare Approved Amounts****	$0	$0	~~[$100]~~ $[135] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of ~~[$4000]~~ [$4620])*
BLOOD First 3 pints	$0	50%	50%♦
Next ~~[$100]~~ $[135] of Medicare Approved Amounts****	$0	$0	~~[$100]~~ $[135] (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to ~~[$4000]~~ $[4620] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN K

PARTS A & B

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

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

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of ~~[$2000]~~ $[2310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~[$876]~~ $[1068]	~~[$657]~~ $[808.50] (75% of Part A deductible)	~~[$219]~~ $[267] (25% of Part A deductible)♦
61st thru 90th day	All but ~~[$219]~~ $[267] a day	~~[$219]~~ $[267] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~[$438]~~ $[534] a day	~~[$438]~~ $[534] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~[$109.50]~~ $[133.50] a day	Up to ~~[$82.13]~~ $[100.13] a day	Up to ~~[$27.37]~~ $[33.38] a day♦
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
BLOOD First 3 pints Additional amounts	 $0 100%	 75% $0	 25%♦ $0
HOSPICE CARE ~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services.~~ You must meet Medicare's requirements, including a doctor's certification of terminal illness.	~~Generally, most Medicare-eligible expenses~~ All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	75% of ~~coinsurance or copayments~~ copayment/ coinsurance	25% of ~~coinsurance or copayments~~ copayment/ coinsurance ♦

(continued)

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

PLAN L

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

**** Once you have been billed ~~[$100]~~ $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
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]~~ $[135] of Medicare Approved Amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	$0 Generally 75% or more of Medicare approved amounts Generally 80%	$0 Remainder of Medicare approved amounts Generally 15%	~~[$100]~~ $[135] (Part B deductible)**** ♦ All costs above Medicare approved amounts Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of ~~[$2000]~~ [$2310])*
BLOOD First 3 pints Next ~~[$100]~~ $[135] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	$0 $0 Generally 80%	75% $0 Generally 15%	25%♦ ~~[$100]~~ $[135] (Part B deductible) ♦ Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to ~~[$2000]~~ $[2310] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN L

PARTS A & B

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

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

PLAN M

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[534](50% of Part A deductible)	$[534](50% of Part A deductible)
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
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 $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

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

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

PLAN M

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $[135] of Medicare Approved Amounts*	$0	$0	$[135] (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 $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068](Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used: —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 $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

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

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

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

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

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

   b. Applications provided to persons eligible for medicare for the health insurance policies for certificates described in subdivision a of subsection 4 must disclose, using the applicable statement in appendix C, the extent to which the policy duplicates medicare. The disclosure statement must be provided as a part of, or together with, the application for the policy or certificate.

History: Effective January 1, 1992; amended effective August 1, 1992; July 1, 1994; April 1, 1996; July 1, 1998; August 27, 1998; December 1, 2001; September 1, 2005; ___________.
General Authority: NDCC 26.1-36.1-03, 26.1-36.1-05
Law Implemented: NDCC 26.1-36.1-05

45-06-01.1-15. Requirements for application forms and replacement coverage. – No amendments

45-06-01.1-16. Filing requirements for advertising. – No amendments

45-06-01.1-17. Standards for marketing. - No amendments

45-06-01.1-18. Appropriateness of recommended purchase and excessive insurance. – No amendments

45-06-01.1-19. Reporting of multiple policies. – No amendments

45-06-01.1-20. Prohibition against preexisting conditions, waiting periods, elimination periods, and probationary periods in replacement policies or certificates. – No amendments

45-06-01.1-20.1. Prohibition against use of genetic information and requests for genetic testing. This section applies to all policies with policy years beginning on or after May 21, 2009.

1. An issuer of a medicare supplement policy or certificate shall not:

   a. Deny or condition the issuance or effectiveness of the policy or certificate, including the imposition of any exclusion of benefits under the policy based on a preexisting condition, on the basis of the genetic information with respect to such individual; and

   b. Discriminate in the pricing of the policy or certificate, including the adjustment of premium rates, of an individual on the basis of the genetic information with respect to such individual.

2. Nothing in subsection a shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

   a. Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

   b. Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group.

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

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

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

6. Notwithstanding subsection 3, an issuer of a medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

   a. The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.

   b. The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

      (1) Compliance with the request is voluntary; and

      (2) Noncompliance will have no effect on enrollment status or premium or contribution amounts.

   c. No genetic information collected or acquired under this subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

   d. The issuer notifies the secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted.

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

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

8. An issuer of a medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

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

10. For the purposes of this section only:

    a. "Issuer of a medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer.

    b. "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

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

    d. "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

e. "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

f. "Underwriting purposes" means:

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

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

(3) The application of any preexisting condition exclusion under the policy; and

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

History: Effective ______.
General Authority: NDCC 26.1-36.1-02(1)(20, 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-21. Separability. – No amendments

45-06-01.1-22. Effective date. – No amendments

Appendix A – Medicare Supplement Refund Calculation Form – No amendments

Appendix B – Form for Reporting Medicare Supplement Policies – No amendments

Appendix C – Disclosure Statements – No amendments