TO: NAIC Members

FROM: Director Lori Wing-Heier
Chair, Senior Issues (B) Task Force

DATE: February 8, 2018

RE: Implementation Materials for Revisions to Medigap Model

Implementation Guidance for MACRA Revisions to Medigap Model Regulation

The Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") was signed into law on April 16, 2015. Section 401 of MACRA prohibits the sale of Medigap policies that cover Part B deductibles to "newly eligible" Medicare beneficiaries defined as those individuals who: (a) have attained age 65 on or after January 1, 2020; or (b) first become eligible for Medicare due to age, disability or end-stage renal disease, on or after January 1, 2020.

This prohibition applies in all states including waiver states. Issuers selling such policies to "newly eligible" Medicare beneficiaries on or after January 1, 2020 are subject to fines, and/or imprisonment of not more than five years, and/or civil money penalties of not more than $25,000 for each prohibited act. For "newly eligible" persons, references in the law to Medigap plans C and F are deemed as references to plans D and G.

Prior statutory amendments to the federal Medigap standards have most always included: (1) a request to the NAIC to revise the Medigap Model Regulation to conform to the changes; (2) a reference to a "process" for amending the Model Regulation; (3) a specified timeframe for NAIC to approve and adopt the changes to the Model Regulation; and (4) a specified timeframe for states to adopt the revised Model Regulation.

MACRA included none of this guidance. As a result, because the NAIC is responsible for maintaining the Model Regulation's conformity to federal statutory standards, we have developed this implementation guidance for states based upon prior federal statutory guidance for previous changes to the Medigap standards. This guidance includes FAQs on the new revisions.

The Senior Issues Task Force established a Medigap Subgroup pursuant to the Social Security Act at Section 1882(p)(2)(D) and (E) to revise the Model Regulation consistent with Section 401 of MACRA. The revisions were approved by the Health Insurance and Managed Care (B) Committee on April 4, 2016, at the NAIC Spring Meeting. These revisions were adopted by the NAIC on August 29, 2016.

The NAIC sent the approved Model to the federal Centers for Medicare & Medicaid Services (CMS) on October 14, 2016 for publication of a notice in the *Federal Register* recognizing the NAIC revisions to the federal minimum standard. CMS published that notice in the *Federal Register* on September 1, 2017.

The statutory directives included in prior amendments by Congress have consistently directed that the changes to the Model Regulation must be adopted by the States one year after the date the NAIC adopted the amended Model Regulation.

In these past circumstances, Congress has provided special consideration in the case where changes to the Model Regulation require the enactment of State legislation. In such cases, Congress also has consistently provided that instead of one year after the date the NAIC adopts the amended Model Regulation, a State requiring legislation will have additional time. **In all cases, States must timely adopt the changes necessary to implement MACRA to be effective January 1, 2020.**

The NAIC urges those states that still need to adopt this regulatory change to complete this task as soon as possible. Failure to adopt this regulation can result in the state losing regulatory authority over the provisions of the MACRA amendments.

MACRA is unique from previous modifications to the Medicare Supplement law in that MACRA does not close the previous blocks of business. MACRA states that for 'newly eligible' only "C or F shall be deemed, as of January 1, 2020, to be a reference to a Medicare Supplemental policy which has a benefit package classified as D or G respectively." MACRA does not state that all plans will have a new effective date as of January 1, 2020. Therefore, except for C and F for "newly eligible" only, all other blocks of plans will remain in the same status as before January 1, 2020.

The NAIC had recommended States to adopt the MACRA revisions before December 31, 2017 in order to give Medigap issuers a timely window to file MACRA compliant amendments to policies and for approval by states. Federal law requires that states adopt standards that are equal to or more stringent than the NAIC Model Regulation, and failure to adopt the MACRA amendments prior to January 1, 2020, may result in Federal enforcement of the MACRA standards.

Guidance materials are attached. If you have any questions or require any additional information, you may contact David Torian at the NAIC at (202) 471-3979 or dtorian@naic.org.

Materials to Assist in Implementation of Recent Medigap Changes

February 8, 2018

TABLE OF CONTENTS:

SECTION I

ANSWERS TO FREQUENTLY ASKED QUESTIONS

1. Why is the NAIC Medigap Model being revised?

A new federal law was passed on April 16, 2015. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) makes changes to Medigap policies that cover the Part B deductibles for "newly eligible" Medicare Beneficiaries on or after January 1, 2020.

2. What does MACRA require?

As of January 1, 2020, MACRA does the following:

1. Prohibits first dollar Part B coverage on Medicare Supplement plans (Plans C and F) to "newly eligible" Medicare Beneficiaries; so Plans C and F cannot be sold to those "newly eligible" for Medicare. Those enrolled in Plans C and F prior to January 1, 2020 may keep their plan.

2. Makes Plans D and G the guarantee issue plans for "newly eligible" Medicare Beneficiaries for the specified periods under current law that name C or F for current Medicare beneficiaries.

3. Who is considered a "newly eligible" Medicare beneficiary under MACRA?

MACRA defines "newly eligible" as anyone who: (a) attains age 65 on or after January 1, 2020, or (b) who first becomes eligible for Medicare benefits due to age, disability or end-stage renal disease on or after January 1, 2020.

4. Do the MACRA changes impact waivered states?

Three states (MA, MN and WI) obtained waivers from implementing the standardized Medicare Supplement plans because these states already had statewide standardized plans prior to 1990. Yes, these waivered states must comply with eliminating coverage for the Part B deductible.

5. How much is the Medicare Part B deductible?

For 2018, the Medicare Part B deductible is $183. For more information please contact Medicare or your local Social Security office.

6. How does this relate to efforts to eliminate Medigap "first dollar coverage"?

This accomplishes the efforts to eliminate Medigap "first dollar coverage" (coverage of all claims without paying any out of pocket cost) by discontinuing sale of Plan C and Plan F only for "newly eligible" Medicare Beneficiaries.

7. Who developed these model revisions?

The Medigap (B) Subgroup was created to make the specific changes. The Subgroup consisted of a collaborative group of NAIC representatives, state regulators, consumer representatives and industry representatives. The Subgroup developed the new Model language and plan charts. The Senior Issues (B) Task Force adopted the model changes on April 3, 2016. The Health Insurance and Managed Care (B) Committee adopted the model changes on April 4, 2016.

8. When were these revisions adopted by the NAIC?

The NAIC Ex/Plenary adopted the model changes on August 29, 2016. The model was sent to the Centers for Medicare & Medicaid Services (CMS) for review and publication as amending the federal minimum standards.

9. Why must states adopt these changes?

States that want to retain regulatory authority over Medicare Supplement products in their state must implement any changes to federal laws impacting Medicare Supplement policies. Failure to adopt the current laws could result in a state losing regulatory authority over these products. Authority to regulate these products would revert back to the Federal Government.

10. Why are these model revisions different from other NAIC model revisions?

Most model revisions are due to trends in the insurance marketplace or changes in state law. Model revisions on Medicare Supplement policies are generated by passage of Federal laws. Also, Medigap models are adopted as rules (which require mostly only state agency involvement) while other model laws require legislative changes to statutes.

11. When do states need to make changes to their Medigap rules? What other key implementation dates do states need to be aware of?

In order to provide enough time for the health plans to create compliant products and to get those products filed and approved by their state insurance regulators, States are encouraged to adopt the necessary changes immediately.

12. Do waiver states have to adopt these changes?

Yes, waiver states (MA, MN and WI) must adopt these changes so that their Medigap rules conform to federal law.

13. What happens if a state does not adopt the changes?

States that fail to adopt the changes risk losing their regulatory authority over the MACRA provisions now contained in the NAIC Medigap Model Regulation that is now the federal minimum standard.

14. What are the penalties for entities that sell Plans C and F policies to the newly eligible on or after January 1, 2020?

Any person or company who sells or issues such policies to "newly eligible" Medicare beneficiaries after that date would be subject to fines, and/or imprisonment of not more than five years, and/or civil money penalties of not more than $25,000 for each prohibited act.

15. How are people eligible for Medicare on the basis of disability impacted by these changes?

Current beneficiaries are not impacted. The restrictions under MACRA apply to persons who qualify for Medicare as a result of a disability on or after January 1, 2020.

16. Why are plans "redesignated" for only "newly eligible" Medicare beneficiaries?

The Federal Government wanted to eliminate coverage for the Part B deductible making consumers responsible for that first dollar coverage. The only difference between Plans C and F and Plans D and G is the coverage of the Part B deductible under Plans C and F. All other benefits are exactly the same for D and G. Since Plans C and F will no longer be available for "newly eligible" beneficiaries, it was necessary to designate Plans C and F as Plans D and G for these individuals.

17. How are enrollees in current Plans C and F affected by these changes?

Current enrollees (those eligible for Medicare PRIOR to January 1, 2020) can continue with their Plan C or Plan F, including F High Deductible plan, and may continue to buy Plans C and F beyond January 1, 2020. Current

enrollees will also be able to buy the new Plan G High Deductible plan on or after January 1, 2020.

18. What changes are made to High Deductible Plan options?

Since Plan F High Deductible cannot be sold to those "newly eligible" Medicare beneficiaries, a new Plan G High Deductible is created for those "newly eligible" Medicare beneficiaries as of January 1, 2020. The effective date of coverage for Plan G High Deductible must be on or after January, 1 2020. If you are not a "newly eligible" beneficiary and are enrolled in a Plan F High Deductible prior to January 1, 2020, you are able to continue this coverage beyond January 1, 2020 and to purchase this coverage on or after January 1, 2020.

19. When can the new High Deductible Plan G be sold and who can buy it?

Plan G High Deductible can be made available beginning on January 1, 2020; "newly eligible" Medicare beneficiaries and current beneficiaries would be able to buy the new Plan G High Deductible.

20. For high deductible plans, does payment of the Part B deductible count towards the plan deductible?

For Plan G High Deductible; while the Part B deductible is not covered (reimbursed), it does count towards the High Deductible plan's deductible. If, in the rare circumstance the Plan G's High Deductible is met with all Part A expenses and Part B Deductible expenses are then incurred, these expenses will not be covered expenses until the beneficiary meets the Medicare Part B deductible.

21. For the new High Deductible Plan G sold on or after January 1, 2020, , what happens if a policyholder meets the high deductible amount with all Part A out of pocket expenses?

If, in the rare circumstance the Plan G's High Deductible is met with all Part A expenses any Part B Deductible expenses incurred will not count towards meeting the High Deductible nor will they be covered expenses.

22. What changes are made to Guaranteed Issue requirements?

Since two of the current guaranteed issue plans, Plans C and F, will no longer be available for "newly eligible" Medicare Beneficiaries on or after January 1, 2020, Plans D and G will become two of the guaranteed issue plans for these individuals. Current enrollees can remain with or buy Plans C and F and individuals who do not fall within the definition of "newly eligible" Medicare beneficiary will still be able to purchase Plans C and F.

23. How does this change the way Plans C or F, and D or G, may be sold in the state?

Insurers can continue to sell Plans C or F to current Medicare beneficiaries. However, "newly eligible" Medicare beneficiaries cannot apply for or purchase Plan C or F. The "newly eligible" would be offered Plans D or G on a guaranteed issue basis instead. All other currently available plans may continue to be offered to all Medicare beneficiaries regardless of their date of eligibility for Medicare.

24. Will the NAIC Medicare Supplement Compliance Manual be updated to reflect these new changes? What is the timeline for those changes?

Yes. The NAIC Medicare Supplement Compliance Manual will be updated prior to January 1, 2020.

25. When will "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" be revised to include these new changes?

We anticipate that CMS will update the "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" prior to January 1, 2020.

CMS provided the following question and response. Refer to CMS for further clarification:

26. Under section 9.2 B., if an individual turns 65 before January 1, 2020, but does not become eligible for Medicare (retroactively or otherwise) before that date, would the individual be eligible to purchase a Medigap Plan C or F at such time as he or she becomes entitled to Medicare Part A and enrolled in Part B, regardless of when that happens?

CMS Response:

Yes, to be considered a "newly eligible Medicare beneficiary" who is ineligible to purchase a Plan C or F, an individual must BOTH have turned 65 on or after January 1, 2020, AND first become Medicare eligible on or after that date. If an individual becomes Medicare eligible before January 1, 2020 based on disability or ESRD status, OR turns 65 before January 1, 2020, whether eligible for Medicare on that date or not, they would be eligible to buy a Plan C or F when they are entitled to Medicare Part A and enrolled in Part B.

CMS Example:

Question: I turn 65 in November 2019 and am eligible for Medicare. If I'm still working and covered by my employer-group employee medical plan, there might not be any reason for me to enroll in Part B during my birthday month. If I elect not to enroll, and end up enrolling when I retire sometime after 1/1/2020, would I be viewed as a "newly eligible" Medicare beneficiary and as a result would not be able to by C or F?

Answer: You are NOT considered "newly eligible" because you turned age 65 before January 1, 2020; and although you must enroll in Part B to purchase Medigap and that would occur after January 1, 2020, you could purchase C or F because you turned age 65 before January 1, 2020.

SECTION II

STATE CONTACTS:

The following state regulators participated in the development of the Medigap model revisions and are available to assist other state regulators:

Mary Mealer
Missouri
573-751-3365
Mary.Mealer@insurance.mo.gov

Martin Swanson
Nebraska
402-471-2201
Martin.Swanson@nebraska.gov

SECTION III

SECTION-BY-SECTION ANALYSIS OF MODEL CHANGES

A description of changes to Section 9.1 E (7) and Section 9.2 of the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651) are provided below.

Note that revisions that are purely cosmetic or stylistic, including minor changes to cross-references or inclusion of effective dates, have not been included in this document.

Section 9.1E Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After June 1, 2010

(7) Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1 C (1), (3), (5), and (6), respectively. Effective January 1, 2020, the standardized benefit plans described in Section 9.2 A (4) of this regulation (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

The purpose of adding the last sentence to Section 9.1 E(7) is to clarify and make consistent that the mandate by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to redesignate Medicare Supplement Plan F as Medicare Supplement Plan G also includes Medicare Supplement Plan F With High Deductible to be redesignated as Medicare Supplement Plan G With High Deductible.

Section 9.2 Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to Individuals Newly Eligible for Medicare on or After January 1, 2020.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of [-insert proper state citation-].

A. Benefit Requirements. The standards and requirements of Section 9.1 shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

(1) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in Section 9.1 E. (3) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

(2) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in Section 9.1 E. (5) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

(3) Standardized Medicare supplement benefit plans C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

(4) Standardized Medicare supplement benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and shall provide the benefits contained in Section 9.1 E. (6) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.

Drafting Note: Subsection A.(4), above implements the High Deductible Plan G as a redesignation of the prior High Deductible Plan F because federal law "deems" any reference to Plan F as Plan G for "newly eligible" Medicare beneficiaries. High Deductible Plan G is the same as the High Deductible Plan F except that where the annual out-of-pocket expenses are met with Medicare Part A expenses only, any subsequent Medicare Part B deductible expense incurred by the beneficiary after the required annual out-of-pocket expenses is met may not be paid for by the High Deductible Plan G. Federal law prohibits the sale or issuance of any Medigap policy that provides coverage (i.e. third party payment) of the Part B deductible to a "newly eligible" Medicare beneficiary and was enacted for the purpose of increasing cost-sharing and reducing "first dollar coverage". Treating the Medicare Part B deductible as an out-of-pocket expense of the beneficiary under Plan G High Deductible meets this purpose.

(5) The reference to Plans C or F contained in Section 9.1 A (2) is deemed a reference to Plans D or G for purposes of this section.

B. Applicability to Certain Individuals. This Section 9.2 applies to only individuals that are newly eligible for Medicare on or after January 1, 2020:

(1) by reason of attaining age 65 on or after January 1, 2020; or

(2) by reason of entitlement to benefits under part A pursuant to section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020.

C. Guaranteed Issue for Eligible Persons. For purposes of Section 12.E, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F With High Deductible) shall be deemed to be a reference to Medicare supplement policy D or G (including G With High Deductible) respectively that meet the requirements of this Section 9.2A.

D. Applicability to Waivered States. In the case of a State described in Section 1882(p)(6) of the Social Security Act ("waivered" alternative simplification states) MACRA prohibits the coverage of the Medicare Part B deductible for any Medicare supplement policy sold or issued to an individual that is newly eligible for Medicare on or after January 1, 2020.

E. Offer of Redesignated Plans to Individuals Other Than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in subparagraph A.(4), above may be offered to any individual who was eligible for Medicare prior to January 1, 2020 in addition to the standardized plans described in section 9.1 E of this regulation.

Drafting Note: The standardized benefit plans described in subparagraphs A (1) and A (2) above in this Section are also included as benefit plans D and G in Section 9.1.E (4) and (7).

The purpose of adding Section 9.2 is to comply with the mandate of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to prohibit the sale of Medigap policies that cover Part B deductibles to "newly eligible" Medicare beneficiaries defined as those individuals who become eligible for Medicare due to age, disability or end-stage renal disease, on or after January 1, 2020.

SECTION IV

NEW CHARTS

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✔ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or Copayment	✔	✔	✔	✔	50%	75%	✔	✔ copays apply[3]	✔	✔
Blood (first three pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Skilled nursing facility coinsurance			✔	✔	50%	75%	✔	✔	✔	✔
Medicare Part A deductible		✔	✔	✔	50%	75%	50%	✔	✔	✔
Medicare Part B deductible									✔	✔
Medicare Part B excess charges				✔						✔
Foreign travel emergency (up to plan limits)			✔	✔			✔	✔	✔	✔
Out-of-pocket limit in [2018][2]					**[$5,240][2]**	**[$2,620][2]**				

1 Plans F and G also have a high deductible option which require first paying a plan deductible of [$2240] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

2 Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

3 Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

PLAN G or HIGH DEDUCTIBLE 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.

[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2240] deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are [$2240]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1340]	$[1340] (Part A deductible)	$0
61st thru 90th day	All but $[335] a day	$[335] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $[670] a day	$[670] 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 $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] 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 $[167.50] a day	Up to $[167.50] 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

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

PLAN G or HIGH DEDUCTIBLE PLAN G
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[183] 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 G after you have paid a calendar year [$2240] deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are [$2240]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] 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 $[183] of Medicare Approved amounts*	$0	$0	[$183] (Unless Part B deductible has been met)
Remainder of Medicare Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess c Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved amounts*	$0	$0	[$183] (Unless Part B deductible has been met)
Remainder of Medicare Approved amounts	80%	20%	$0

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G or HIGH DEDUCTIBLE PLAN G PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,]** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
- First $[183] of Medicare Approved Amounts*	$0	$0	[$183] (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] 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 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 you have paid a calendar year [$2240] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2240]. 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 $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1340]	$[1340] (Part A deductible)	$0
61st thru 90th day	All but $[335] a day	$[335] a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $[670] a day	$[670] 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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] 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 $[167.50] a day	Up to $[167.50] 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $[183] 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 you have paid a calendar year [$2240] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2240]. 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 $[2240] DEDUCTIBLE,*] PLAN PAYS	[IN ADDITION TO $[2240] 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 $[183] of Medicare Approved amounts*	$0	$[183] (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 $[183] of Medicare Approved amounts*	$0	$[183] (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F or HIGH DEDUCTIBLE PLAN F

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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,*] PLAN PAYS	[IN ADDITION TO $[2240] 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 $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
–First $[183] of Medicare Approved Amounts*	$0	$[183] (Part B deductible)	$0
–Remainder of Medicare — Approved Amounts	80%	20%	$0

PLAN F or HIGH DEDUCTIBLE PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] 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