RULES AND REGULATIONS

Title 31—INSURANCE

INSURANCE DEPARTMENT

[31 PA. CODE CH. 89]

Medicare Supplement Insurance

The Insurance Department (Department) hereby amends Chapter 89, Subchapter K (relating to Medicare supplement insurance minimum standards) to read as set forth in Annex A. Sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412) provide the Insurance Commissioner (Commissioner) with the authority and duty to promulgate regulations governing the enforcement of the laws relating to insurance.

Notice of the proposed rulemaking is omitted in accordance with section 204(3) of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. § 1204(3)) (CDL). In accordance with section 204(3) of the CDL, notice of proposed rulemaking may be omitted when the agency for good cause finds that public notice of its intention to amend an administrative regulation is, under the circumstances, impracticable and unnecessary.

Purpose

The amendments will bring the Department's regulation for the approval of Medicare supplement policies into compliance with the Federal statutory requirements of the Social Security Act (42 U.S.C.A. § 1395ss), the Balanced Budget Refinement Act of 1999 (Pub.L. No. 106-113) (BBRA) and the Ticket to Work and Work Incentives Improvement Act (Pub.L. No. 106-170).

The changes, indicated to Subchapter K, are Federally mandated under recent Federal legislation, the Balanced Budget Refinement Act of 1999, with a November 29, 1999, effective date and the Ticket to Work and Work Incentives Improvement Act, with a December 17, 1999, effective date. The Federal law also establishes a timetable under which these changes are to be implemented by the states if they are to remain in compliance with the Federal requirements and maintain regulatory authority in this area. The new regulations must be adopted within 1 year following the NAIC September 2000 adoption of the model regulations. To comply with Federal statutory minimum requirements for Medicare supplement policies, as mandated by sections 501 (a) and 536 of the Balanced Budget Refinement Act of 1999, and the section 205 of the Ticket to Work and Work Incentives Improvement Act, the Commissioner finds that the proposed rulemaking procedures in sections 201 and 202 of the CDL (45 P. S. §§ 1201 and 1202) are impracticable and unnecessary in this situation, and that the proposed rulemaking may be properly omitted under section 204(3) of the CDL.

Subchapter K was initially promulgated to establish minimum standards for Medicare supplement insurance policies. Standardization of policies was Federally required under the Omnibus Budget Reconciliation Act of 1990. The Department currently seeks to modify Subchapter K to meet the new Federal mandates for Medicare supplement policies as required under the Balanced Budget Refinement Act of 1999 and the Ticket to Work and Work Incentives Improvement Act.

These amendments are necessary in order to maintain the Commonwealth's compliance with Federal requirements. This will ensure that the Commonwealth retains enforcement authority over these new requirements. These standards will be implemented through Federal preemption if the Commonwealth does not implement these changes through State regulation within 1 year after NAIC adoption of the revised model regulation. States that adopt the NAIC model regulation as stated in the Omnibus Budget Reconciliation Act of 1990 and as amended in 42 U.S.C.A. § 1395ss (relating to Medicare Supplemental policies) will be considered states with an approved plan and considered in compliance with the act. The Balanced Budget Act of 1997 (Pub.L. No. 105-33) (BBA of 1997) and the BBRA of 1999 amended that act.

These amendments will protect the rights of consumers of this Commonwealth purchasing Medicare supplement policies.

Explanation of Regulatory Requirements

Section 89.772 (relating to definitions) has been amended to include the United States Code citation. The added language to Medicare + Choice is based on the revised NAIC Medicare Supplement model regulation.

Section 89.776 (relating to benefit standards) has been modified. Section 89.776(1)(vii)(C) has been revised to reflect the new Federal requirements under the Ticket to Work and Work Incentives Improvement Act amending the suspension of benefits and premiums under a Medicare Supplement policy due to coverage under a group health plan. The new language is based on the revised NAIC Medicare Supplement model regulation.

Section 89.776(2)(v) has been amended to reflect the new payment system for Medicare outpatient hospital services. The new language is based on the revised NAIC Medicare Supplement model regulation.

Section 89.776(3)(ix)(B) has been amended to reflect changes to the preventive medical care benefit. The fecal occult blood test and a mammogram test are being deleted. This correction is a result of the Balanced Budget Refinement Act of 1999 adding coverage to Medicare Part B and should not be included in benefits covered under a Medicare Supplement policy. This new language is based on the revised NAIC Medicare Supplement model regulation.

Section 89.776(3)(ix)(C) has been amended to reflect changes to the preventive medical care benefit. The influenza vaccination is being deleted and moved to the basic services. This correction is a result of the Balanced Budget Refinement Act of 1999 adding coverage to the Medicare Part B and should not be included in benefits covered under a Medicare Supplement policy. This new language is based on the revised NAIC Medicare Supplement model regulation.

Section 89.783(a)(6) has been amended to italicize the name of the *Guide to Health Insurance for People with Medicare*, and the word *Guide* in italics is being used as an abbreviation. The new language is based on the revised NAIC Medicare Supplement model regulation.

Section 89.783(c)(5) has been amended to correctly title the Medicare handbook to "Medicare & You." Changes to the outline of coverages in outpatient services and plan specific deductibles are being changed. The new language is based on the revised NAIC Medicare Supplement model regulation.

Section 89.783 is also being revised to reflect the 2001 Medicare deductibles as announced by the Department of Health and Human Services (HHS) on October 18, 2000. Each year HHS establishes the deductibles for inpatient hospital care. The increase in Medicare hospital payments was signed into law in the BBA help to protect and to preserve the Medicare Hospital Insurance Trust Fund.

Section 89.790(a)(1) (relating to guaranteed issue for eligible persons) has been changed to broaden the definition of an eligible person as in subsection (a)(2) and (b)(1) to meet new Federal requirements under the Balanced Budget Refinement Act of 1999. The new language is based on the revised NAIC Medicare Supplement model regulation.

Section 89.790(b)(2) expands the class of persons eligible for guaranteed issue to include individuals who are 65 years of age or older and enrolled in the Program of All-inclusive Care for the Elderly (PACE). The language is a result of section 536 of the Balanced Budget Refinement Act of 1999. This language was adopted by the NAIC model regulation.

Section 89.790(b)(2)(vi) and (vii) is being amended to provide that a beneficiary may elect to begin the beneficiary guaranteed issue period upon receipt of notification of impending termination of a Medicare+Choice plan. This establishes that a beneficiary does not have to wait until actual termination of the Medicare+Choice plan to apply and receive a guaranteed issue Medicare Supplement policy. This language is a result of section 501(a) of the Balanced Budget Refinement Act of 1999. This language is based on the revised NAIC model regulation.

Section 89.790(b)(5) adds any PACE program under section 1894 of the SSA as an eligible organization. The language is a result of the Balanced Budget Refinement Act of 1999. This language was adopted by the NAIC model regulation.

Section 89.790(b)(6) adds the PACE program under section 1894 as an eligible program from which to disenroll within 12 months after the effective date. This language is based on the revised NAIC model regulation.

Fiscal Impact

The Department can review revised Medicare supplement filings in the course of normal business and anticipates that it will experience minimal or no increase in cost in its review.

The insurance industry will likely not incur additional costs associated with complying with the new Federal requirements. The guaranteed eligibility provisions may increase the utilization of services and therefore, the cost of policies. There is currently no way to assess these potential costs.

Effectiveness/Sunset Date

These amendments are effective upon publication in the *Pennsylvania Bulletin*. No sunset date has been assigned.

Paperwork

Adoption of final-omitted rulemaking should not require significant paperwork for insurance carriers' product development areas to implement the new Federal changes.

Persons Regulated

This final-omitted rulemaking applies to all insurance companies who issue Medicare supplement products in this Commonwealth.

Contact Person

Questions regarding the final-omitted rulemaking may be addressed to Peter J. Salvatore, Regulatory Coordinator, Pennsylvania Insurance Department, 1326 Strawberry Square, Harrisburg, PA 17120, (717) 787-4429. Questions may also be e-mailed to psalvatore@state.pa.us or faxed to (717) 772-1969.

Regulatory Review

Under section 5.1(c) of the Regulatory Review Act (71 P. S. § 745.5a), on November 6, 2000, the Department submitted a copy of this final-omitted rulemaking to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Committee on Insurance and the Senate Committee on Banking and Insurance. On the same date, the final-omitted rulemaking was submitted to the Office of Attorney General for review and approval under the Commonwealth Attorneys Act (71 P. S. §§ 732-101—732-506).

In accordance with section 5.1(d) of the Regulatory Review Act, the final-omitted rulemaking was deemed approved by the Senate and House Committees on November 27, 2000. IRRC met on December 14, 2000, and approved the final-omitted rulemaking.

Findings

The Commissioner finds that:

(1) There is good cause to amend Subchapter K, effective upon publication with proposed rulemaking omitted. Deferral of the effective date of these regulations would be impractical and not serve the public interest. Under section 204(3) of the CDL, there is no purpose to be served by deferring the effective date. An immediate effective date will best serve the public interest by ensuring the Commonwealth's compliance with the new Federal requirements and retention of enforcement authority over all aspects of Medicare supplement policies.

(2) There is good cause to forego public notice of the intention to amend Subchapter K, because notice of the amendment under the circumstances is unnecessary and impractical for the following reasons:

(i) The changes mandated by Federal law will go into effect with or without Pennsylvania regulatory action.

(ii) If the amendments are not implemented as established by the Federal law, regulatory oversight of these requirements will be assumed by the Federal government. If this were to occur, it would split regulation of Medicare supplement policies between the Commonwealth and the Federal government. The dual regulation would negatively impact consumers of this Commonwealth due to a shortage in Federal enforcement staffing. Accordingly, it would be more difficult for consumers of this Commonwealth to have complaints concerning the new requirements addressed by the Federal government in a timely manner.

(iii) Public comment cannot change the fact that these Federal requirements will be implemented by either the Commonwealth or the Federal government. Nor can public comment have any impact upon the content of the new Federal mandates.

Order

The Commissioner, acting under the authority in sections 206, 506, 1501 and 1502 of The Administrative Code of 1929, orders that:

(a) The regulations of the Department, 31 Pa.Code Chapter 89, are amended by amending §§ 89.772, 89.776,

89.783 and 89.790 to read as set forth in Annex A, with ellipses referring to the existing text of the regulations.

(b) The Department shall submit this order and Annex A to the Office of Attorney General and the Office of General Counsel for approval as to form and legality as required by law.

(3) The Department shall certify this order and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(4) This order shall take effect upon its publication in the *Pennsylvania Bulletin*.

M. DIANE KOKEN,
Insurance Commissioner

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission relating to this order, see 30 Pa.B. 6964 (December 30, 2000).)

Fiscal Note: 11-205. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 31. INSURANCE

PART IV. LIFE INSURANCE

CHAPTER 89. APPROVAL OF LIFE, ACCIDENT, AND HEALTH INSURANCE

Subchapter K. MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

§ 89.772. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

* * * * *

Medicare + Choice plan—A plan of coverage for health benefits under Medicare Part C as defined in section 1859 (b)(1) of the Social Security Act (42 U.S.C.A. § 1395w-28(b)(1)) and includes:

* * * * *

§ 89.776. Benefits standards for policies or certificates issued or delivered on or after July 30, 1992.

The following standards apply to Medicare supplement policies or certificates delivered or issued for delivery in this Commonwealth on or after July 30, 1992. A policy or certificate may not be advertised, solicited, delivered or issued for delivery in this Commonwealth 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 other requirements of this subchapter:

* * * * *

(vii) *Suspension by policyholder*.

(C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act (42 U.S.C.A. § 426(b)) and is covered under a group health plan (as defined in section 1862 (b)(1)(A)(v) of the Social Security Act (42 U.S.C.A. § 1395y (b)(ii)(A)(v)). 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 90 days after the date of the loss and pays the premium attritutable to the period, effective as of the date of termination of entitlement.

(D) Reinstitution of these coverages:

* * * * *

(2) *Standards for basic (core) benefits common to all benefit plans*. Every issuer shall make available a policy or certificate, including only the following basic core package of benefits to each prospective insured. An issuer shall also offer a policy or certificate to prospective insureds meeting the Plan B benefit plan. An issuer may make available to prospective insureds Medicare Supplement Insurance Benefit Plans C, D, E, F, G, H, I and J as listed in § 89.777(e) (relating to standard Medicare supplement benefit plans). The core packages are as follows:

* * * * *

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

(3) *Standards for additional benefits*. The following additional benefits shall be included in Medicare Supplement Benefit Plans B, C, D, E, F, G, H, I and J only as provided by § 89.777.

* * * * *

(ix) *Preventive medical care benefit*. Reimbursement shall be for the actual charges up to 100% of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit may not include payment for a procedure covered by Medicare. Coverage for the preventive health services is as follows:

* * * * *

(B) One or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(I) Digital rectal examination.

(II) Dipstick urinalysis for hematuria, bacteriuria and proteinuria.

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

(IV) Serum cholesterol screening every 5 years.

(V) Thyroid function test.

(VI) Diabetes screening.

(C) Tetanus and Diphtheria booster every 10 years.

* * * * *

§ 89.783. Required disclosure provisions.

(a) *General rules*.

* * * * *

(6) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person eligible for Medicare, shall provide to these applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing

Administration and in a type size no smaller than 12-point type. Delivery of the *Guide* shall be made whether or not these policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this subchapter. Except in the case of direct response issuers, delivery of the *Guide* shall be made to the applicant at the time of application and acknowledgment of receipt of the *Guide* shall be obtained by the issuers. Direct response issuers shall deliver the *Guide* to the applicant upon request but not later than at the time the policy is delivered.

* * * * *

(c) *Outline of coverage requirements for Medicare supplement policies.*

* * * * *

(5) The following items shall be included in the outline of coverage in the order prescribed in this paragraph:

* * * * *

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

* * * * *

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page:

Benefit Plans _____ (insert letters of plans being offered)

Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan A & B.

Basic Benefits: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses) or, in the case of hospital outpatient department services under a prospective payment system, applicable copayments.
Blood: First three pints of blood each year.

A	*B*	*C*	*D*	*E*	*F*	*F**	*G*	*H*	*I*	*J*	*J**
Basic	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled	Skilled	Skilled	Skilled		Skilled	Skilled	Skilled	Skilled	
	Part A	Part A	Part A	Part A	Part A		Part A	Part A	Part A	Part A	
		Part B			Part B					Part B	
					Part B Excess		Part B Excess		Part B Excess	Part B Excess	
		Foreign Travel	Foreign	Foreign	Foreign		Foreign	Foreign	Foreign	Foreign	
			At-Home				At-Home		At-Home	At-Home	
								Basic Drugs	Basic Drugs	Extended	
				Preventive						Preventive	

Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year $1,580* deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are $1580. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does not include, in plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.

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			$792 (Part A deductible)
First 60 days	All but $792	$0	
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $396 a day	$396 a day	$0
—Once lifetime reserve days are used:		100% of Medicare	
—Additional 365 days	$0	eligible expenses	$0
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $99 a day	$0	Up to $99 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN A

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $100 of Medicare approved amounts*			
Remainder of Medicare approved amounts	$0	$0	$100 (Part B deductible
Part B excess charges (Above Medicare approved amounts)	80% (50% outpatient psychiatric services) $0	20% (50% outpatient psychiatric services) $0	$0 All costs

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

PLAN B

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $396 a day	$396 a day	$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 $99 a day	$0	Up to $99 a day
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	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN B

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

PLAN C

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $384 a day	$384 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN C

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

OTHER BENEFITS - 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 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			
61st thru 90th day	All but $792	$792 (Part A deductible)	$0
91st day and after:	All but $198 a day	$198 a day	$0
—While using 60 lifetime reserve days			
—Once lifetime reserve days are used:	All but $396 a day	$396 a day $0	$0
—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 $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN D

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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

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

PLAN E

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

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

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

PLAN E

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

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 life-time maximum
***PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE** Some physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

** This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year $1,580 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $1,580. 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 $1,580 DEDUCTIBLE,** PLAN PAYS*	*IN ADDITION TO $1,580 DEDUCTIBLE,** YOU PAY*
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies	All but $792	$792 (Part A deductible)	$0
First 60 days	All but $198 a day		$0
61st thru 90th day		$198 a day	
91st day and after:			
—While using 60 lifetime reserve days	All but $396 a day	$396 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 $1,580 DEDUCTIBLE,** PLAN PAYS*	*IN ADDITION TO $1,580 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 $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

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

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

** This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year $1,580 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $1,580. 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 $1,580 DEDUCTIBLE,** PLAN PAYS*	*IN ADDITION TO $1,580 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 of Medicare approved amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric service)	20% (50% outpatient psychiatric service)	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	*MEDICARE PAYS*	*AFTER YOU PAY $1,580 DEDUCTIBLE,** PLAN PAYS*	*IN ADDITION TO $1,580 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		$792 (Part A deductible)	
61st thru 90th day	All but $792		$0
91st day and after:	All but $198 a day	$198 a day	$0
—While using 60 lifetime reserve days			
—Once lifetime reserve days are used:	All but $396 a day	$396 a day	$0
—Additional 365 days	$0	100% of Medicare eligible expenses	$0
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $99 a day	Up to $99 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	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN G

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$0
Part B excess charges (Above Medicare approved amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

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 life- time maximum

PLAN H

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

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

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

PLAN H

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First $100 of Medicare approved amounts* Remainder of Medicare approved amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B deductible $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 Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE First $250 each calendar year Next $2,500 each calendar year Over $2,500 each calendar year	 $0 $0 $0	 $0 50%—$1,250 calendar year maximum benefit $0	 $250 50% All costs

PLAN I

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	 All but $792 All but $198 a day All but $396 a day $0 $0	 $792 (Part A deductible) $198 a day $396 a day 100% of Medicare eligible expenses $0	 $0 $0 $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 $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN I

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

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 I

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs

PLAN J or HIGH DEDUCTIBLE PLAN J

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

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

** This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year $1,580 deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are $1,580. 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 prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	*MEDICARE PAYS*	*AFTER YOU PAY $1,580 DEDUCTIBLE,** PLAN PAYS*	*IN ADDITION TO $1,580 DEDUCTIBLE,** YOU PAY*
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $396 a day	$396 a day	$0
—Once lifetime reserve days are used:		100% of Medicare eligible expenses	
—Additional 365 days	$0		$0
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

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

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

** This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year $1,580 deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are $1,580. 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 prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	*MEDICARE PAYS*	*AFTER YOU PAY $1,580 DEDUCTIBLE,** PLAN PAYS*	*IN ADDITION TO $1,580 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 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%(50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

PLAN J or HIGH DEDUCTIBLE PLAN J (cont.)

PARTS A & B (continued)

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 Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE First $250 each calendar year Next $6,000 each calendar year Over $6,000 each calendar year	 $0 $0 $0	 $0 50%—$3,000 calendar year maximum benefit $0	 $250 50% All costs
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare First $120 each calendar year Additional charges	 $0 $0	 $120 $0	 $0 All costs

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

§ 89.790. Guaranteed issue for eligible persons.

(a) *Guaranteed issue.*

(1) Eligible persons are those individuals described in subsection (b) who, subject to subsection (b)(2)(vi) apply to enroll under the policy not later than 63 days after the date of the termination of enrollment described in subsection (b), and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

* * * * *

(b) Eligible persons. An eligible person is an individual described in paragraphs (1)—(6):

* * * * *

(2) The individual is enrolled with a Medicare + Choice organization under a Medicare + Choice plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act (42 U.S.C.A. § 1395eee), and there are circumstances similar to those described as follows that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare+Choice plan:

(i) The certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of the certification.

(ii) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuance of the plan.

(iii) 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 HHS Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the Social Security Act (42 U.S.C.A. § 1395w-21(g)(3)(B)) (when the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856 of the Social Security Act (42 U.S.C.A. § 1395w-26), or the plan is terminated for all individuals within a residence area).

(iv) The individual demonstrates, in accordance with guidelines established by the HHS Secretary, that one of the following applies:

* * * * *

(v) The individual meets other exceptional conditions the HHS Secretary may provide.

(vi) An individual described in paragraph (2) may elect to apply subsection (a) by substituting, for the date of termination of enrollment, the date on which the individual was notified by the Medicare+Choice organization of the impending termination or discontinuance of the Medicare+Choice plan it offers in the area in which the individual resides, but only if the individual disenrolls from the plan as a result of the notification.

(vii) In the case of an individual making the election in subparagraph (vi), the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under subsection A shall only become effective upon termination of coverage under the Medicare+Choice plan involved.

* * * * *

(5) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare + Choice organization under a Medicare + Choice plan under Part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare risk or cost) (42 U.S.C.A. § 1395mm), any similar organization operating under demonstration project authority, any PACE program under section 1894 of the Social Security Act, any organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan) or any Medicare Select policy and the subsequent enrollment under this paragraph is terminated by the enrollee during the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment under section 1851(e) of the Social Security Act).

(6) The individual, upon first becoming eligible for benefits under Part A and enrolled in Part B, if eligible, of Medicare, enrolls in a Medicare + Choice plan under Part C of Medicare, or in a PACE program under section 1894, and disenrolls from the plan or program within 12 months after the effective date of enrollment.

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[Pa.B. Doc. No. 00-2260. Filed for public inspection December 29, 2000, 9:00 a.m.]

Title 49—PROFESSIONAL AND VOCATIONAL STANDARDS

STATE BOARD OF MEDICINE
STATE BOARD OF NURSING
[49 PA. CODE CHS. 18 AND 21]
Corrective Amendment to 49 Pa. Code §§ 18.55(b)(4) and 21.285(b)(4)

The State Boards of Medicine and Nursing (Boards) have discovered a discrepancy between the agency text of 49 Pa. Code §§ 18.55(b)(4) and 21.285(b)(4), as deposited with the Legislative Reference Bureau and the official text published at 30 Pa.B. 5943, 5950 and 5951 (November 18, 2000) and as scheduled to be published in the February 2001 *Pennsylvania Code Reporter* (MTS 315). Subsections (b)(4) incorrectly contained the word "CRNP" instead of "physician."

Therefore, under 45 Pa.C.S. § 901: The Boards have deposited with the Legislative Reference Bureau a corrective amendment to §§ 18.55(b)(4) and 21.285(b)(4). The corrective amendment to §§ 18.55(b)(4) and 21.285(b)(4) is effective November 18, 2000, the date the defective text was published in the *Pennsylvania Bulletin*.

The correct versions of 49 Pa. Code §§ 18.55(b)(4) and 21.285(b)(4) appear in Annex A, with ellipses referring to the existing text of the regulations.

Annex A

TITLE 49. PROFESSIONAL AND VOCATIONAL STANDARDS

PART I. DEPARTMENT OF STATE

Subpart A. PROFESSIONAL AND OCCUPATIONAL AFFAIRS

CHAPTER 18. STATE BOARD OF MEDICINE

Subchapter C. CERTIFIED REGISTERED NURSE PRACTITIONERS

CRNP PRACTICE

§ 18.55. Collaborative agreement

* * * * *

(b) The collaborative agreement between a physician and a CRNP who will prescribe drugs shall satisfy the following requirements. The agreement shall:

* * * * *

(4) Contain attestation by the collaborating physician that the physician has knowledge and experience with any drug that the CRNP will prescribe.

* * * * *

CHAPTER 21. STATE BOARD OF NURSING

Subchapter C. CERTIFIED REGISTERED NURSE PRACTITIONERS

CRNP PRACTICE

§ 21.285. Collaborative agreement.

* * * * *

(b) The collaborative agreement between a physician and a CRNP who will prescribe drugs shall satisfy the following requirements. The agreement shall:

* * * * *

(4) Contain attestation by the collaborating physician that the physician has knowledge and experience with any drug that the CRNP will prescribe.

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[Pa.B. Doc. No. 00-2261. Filed for public inspection December 29, 2000, 9:00 a.m.]