

Sec. 38a-495a-13. Required disclosure provisions

(a) General Rules.

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

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

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

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

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

(6) (A) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and Centers for Medicare and Medicaid Services and in a type size no smaller than 12 point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

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

(b) Notice Requirements.

(1) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner. Such notice shall:

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

(B) Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

(2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) Such notices shall not contain or be accompanied by any solicitation.

(c) **MMA Notice Requirements.** Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

(d) Outline of Coverage Requirements for Medicare Supplement Policies.

(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of such outline from the applicant; and

(2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name:

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

(3) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All plans shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(4) The following items shall be included in the outline of coverage in the order prescribed below.

PREMIUM INFORMATION

We (insert issuer’s name) can only raise your premium if we raise the premium for all policies like yours in this state.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

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

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

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

(for agents)

Neither (insert company's name) nor its agents are connected with Medicare.

(for direct response:)

(insert company's name) is not connected with Medicare.

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

(Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to section 38a-495a-6a(d) of the Regulations of Connecticut State Agencies. For purposes of illustration, the charts below display in parentheses dollar amounts that vary in accordance with the Medicare program. Issuers shall revise such dollar amounts as necessary to ensure that outlines of coverage contain information that is current at the time the outlines are provided to consumers.)

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

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(Illustrative charts follow)

Benefit chart of Medicine Supplement Plans Sold for Effective Dates on or After June 1, 2010

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

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

Basic Benefits:

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

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B insurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility	Skilled Nursing Facility	Skilled Nursing Facility Coin		Skilled Nursing Facility	50% Skilled Nursing Facility Coin	75% Skilled Nursing Facility Coin	Skilled Nursing Facility	Skilled Nursing Facility Coin

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A	B	C	D	F	F*	G	K	L	M	N
		ity Coin- suranc e	ity Coin- suranc e	suranc e	ity Coin- suranc e	surance	surance	surance	ity Coin- suranc e	suranc e
	Part A De- ductibl e	Part A De- ductibl e	Part A De- ductibl e	Part A De- ductibl e	Part A De- ductibl e	50% Part A De- ductible	75% Part A De- ductible	50% Part A De- ductibl e	Part A De- ductibl e	
		Part B De- ductibl e		Part B De- ductibl e						
				Part B Excess (100%)	Part B Excess (100%)					
		For- eign Travel Emer- gency	For- eign Travel Emer- gency	For- eign Travel Emer- gency	For- eign Travel Emer- gency			For- eign Travel Emer- gency	For- eign Travel Emer- gency	
						Out-of- pocket limit (\$5240) ; paid at 100% after limit reached	Out-of- pocket limit (\$2620) ; paid at 100% after limit reached			

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

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

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2020 may purchase plans C, F, and high deductible F. A check mark means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Only Those First Eligible for Medicare Before 2020	
	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%	√	√ co-pays apply ³	√	√
Blood (first 3 pints)	√	√	√	√	50%	75%	√	√	√	√
Part A hospice care coinsurance or copayment	√	√	√	√	50%	75%	√	√	√	√
Skilled nursing facility coinsurance			√	√	50%	75%	√	√	√	√
Medicare		√	√	√	50%	75%	50	√	√	√

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Benefits	Plans Available to All Applicants								Only Those First Eligible for Medicare Before 2020	
	A	B	D	G ¹	K	L	M	N	C	F ¹
Part A deductible							%			
Medicare Part B deductible									√	√
Medicare Part B excess charges				√						√
Foreign travel emergency (up to plan limits)			√	√			√	√	√	√
Out-of-pocket limit in 2018					(\$5240) ²	(\$2620) 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 copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that do not result in an inpatient admission.

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.

Regulations of Connecticut State Agencies

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZA- TION*			
Semiprivate room and board, general nursing and mis- cellaneous services and supplies			
First 60 days	All but \$(1,340)	\$0	\$(1,340) (Part A De- ductible)
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	All but \$(670) a day	\$0
—Once lifetime re- serve days are used:			
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the Ad- ditional 365 days	\$0	\$0	All Costs
SKILLED NURS- ING FACILITY CARE*			
You must meet Medicare's re- quirements, includ- ing 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

Regulations of Connecticut State Agencies

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
21st thru 100th day	All but \$(167.50) a day	\$0	Up to \$(167.50) a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/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 A

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.

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			

Regulations of Connecticut State Agencies

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
speech therapy, diagnostic tests, durable medical equipment			
First \$(183) of Medicare Approved Amounts*	\$0	\$0	\$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges	\$0	\$0	All costs
(Above Medicare Approved Amounts)			
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$(183) of Medicare Approved Amounts*	\$0	\$0	\$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES —tests for diagnostic services	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE Medicare approved services			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$(183) of Medicare Approved	\$0	\$0	\$(183) (Part B Deductible)

Regulations of Connecticut State Agencies

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Amounts*			
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 \$(1,340)	\$(1,340) (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
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			

Regulations of Connecticut State Agencies

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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	\$0	Up to \$(167.50) a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/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 B

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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and			

Regulations of Connecticut State Agencies

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
speech therapy, diagnostic tests, durable medical equipment			
First \$(183) of Medicare Approved Amounts*	\$0	\$0	\$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$(183) of Medicare Approved Amounts*	\$0	\$0	\$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$(183) of Medicare Approved Amounts*	\$0	\$0	\$(183) (Part B Deductible)

Regulations of Connecticut State Agencies

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 \$(1,340)	\$(1,340) (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
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a			

Regulations of Connecticut State Agencies

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/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 C

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.

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			

Regulations of Connecticut State Agencies

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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	\$0	All costs
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
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$(183) of Medicare Approved Amounts*	\$0	\$(183) (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

Regulations of Connecticut State Agencies

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

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$(1,340)	\$(1,340) (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 Eligi- ble Expenses	\$0**
—Beyond the Additional 365 days	\$0	\$0	All Costs

Regulations of Connecticut State Agencies

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 \$(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 copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/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 D

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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—			
IN OR OUT OF THE HOSPI			

Regulations of Connecticut State Agencies

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
TAL 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) (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$(183) of Medicare Approved Amounts*	\$0	\$0	\$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$(183) of Medicare Ap	\$0	\$0	\$(183) (Part B Deductible)

Regulations of Connecticut State Agencies

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
proved Amounts*			
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 life-time maximum benefit of \$50,000	20% and amounts over the \$50,000 life-time 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 one has 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			

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SERVICES	MEDICARE PAYS	(AFTER YOU PAY \$(2240) DE- DUCTIBLE,**) PLAN PAYS	(IN ADDI- TION TO \$(2240) DE- DUCTIBLE,**) YOU PAY
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
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	All but very lim	Medicare copay	\$0

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SERVICES	MEDICARE PAYS	(AFTER YOU PAY \$(2240) DE- DUCTIBLE,**) PLAN PAYS	(IN ADDI- TION TO \$(2240) DE- DUCTIBLE,**) YOU PAY
requirements, including a doctor's certification of terminal illness	ited copayment/coin- surance for outpa- tient drugs and inpatient respite care	ment/coinsurance	

***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 one has 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) DE- DUCTIBLE,**) PLAN PAYS	(IN ADDITION TO \$(2240) DE- DUCTIBLE,**) YOU PAY
MEDICAL EXPENSES-			
IN OR OUT OF THE HOSPI- TAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient med- ical and surgical services and supplies, physical and speech therapy, diagnostic tests,			

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SERVICES	MEDICARE PAYS	(AFTER YOU PAY \$(2240) DE- DUCTIBLE,**) PLAN PAYS	(IN ADDITION TO \$(2240) DE- DUCTIBLE,**) YOU PAY
durable medical equipment			
First \$(183) of Medicare Ap- proved Amounts*	\$0	\$(183) (Part B Deductible)	\$0
Remainder of Medicare Ap- proved 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 Ap- proved Amounts*	\$0	\$(183) (Part B Deductible)	\$0
Remainder of Medicare Ap- proved Amounts	80%	20%	\$0
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) DE- DUCTIBLE,** PLAN PAYS	IN ADDITION TO \$(2240) DE- DUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERV- ICES			
—Medically neces- sary skilled care services and med- ical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$(183) of	\$0	\$(183) (Part B De	\$0

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SERVICES	MEDICARE PAYS	AFTER YOU PAY \$(2240) DE- DUCTIBLE,** PLAN PAYS	IN ADDITION TO \$(2240) DE- DUCTIBLE,** YOU PAY
Medicare Approved Amounts*		ductible)	
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$(2240) DE- DUCTIBLE,** PLAN PAYS	IN ADDITION TO \$(2240) DE- DUCTIBLE,** YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE			
Medically neces- sary emergency care services be- ginning 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 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

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by the policy. This does not include the plan's separate foreign travel emergency deductible.)

SERVICES	MEDICARE PAYS	(AFTER YOU PAY \$(2240) DE- DUCTIBLE,**) PLAN PAYS	(AFTER YOU PAY \$(2240) DE- DUCTIBLE,**) YOU PAY
HOSPITALIZA- TION *			
Semiprivate room and board, general nursing and miscel- laneous services and supplies			
First 60 days	All but \$(1,340)	\$(1,340) (Part A De- ductible)	\$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 re- serve days are used:			
—Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0***
—Beyond the Ad- ditional 365 days	\$0	\$0	All Costs
SKILLED NURS- ING FACILITY CARE*			
You must meet Medicare's require- ments, including having been in a hospital for at least 3 days and entered a Medicare-ap- proved facility within 30 days after leaving the hospital			

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SERVICES	MEDICARE PAYS	(AFTER YOU PAY \$(2240) DEDUCTIBLE,**) PLAN PAYS	(AFTER YOU PAY \$(2240) DEDUCTIBLE,**) YOU PAY
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 copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/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.)

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SERVICES	MEDICARE PAYS	(AFTER YOU PAY \$(2240) DE- DUCTIBLE,**) PLAN PAYS	(AFTER YOU PAY \$(2240) DE- DUCTIBLE,**) YOU PAY
MEDICAL EXPENSES —IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOS- PITAL TREATMENT, such as Physician’s serv- ices, inpatient and outpa- tient medical and surgical services and supplies, physical and speech ther- apy, diagnostic tests, durable medical equipment			
First \$(183) of Medicare Approved Amounts*	\$0	\$0	\$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
(Above Medicare Ap- proved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$(183) of Medicare Approved Amounts*	\$0	\$0	\$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORA- TORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PLAN G or HIGH DEDUCTIBLE PLAN G
PARTS A & B**

Regulations of Connecticut State Agencies

SERVICES	MEDICARE PAYS	(AFTER YOU PAY \$(2240) DE- DUCTIBLE,**) PLAN PAYS	(AFTER YOU PAY \$(2240) DE- DUCTIBLE,**) YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equip- ment First \$(183) of Medicare Approved Amounts*	\$0	\$0	\$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN G or HIGH DEDUCTIBLE PLAN G

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	(AFTER YOU PAY \$(2240) DE- DUCTIBLE,**) PLAN PAYS	(AFTER YOU PAY \$(2240) DE- DUCTIBLE,**) 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 maxi- mum

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual

out-of-pocket limit of \$(5240) each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$(1,340)	\$(670) (50% of Part A deductible)	\$(670) (50% of Part A deductible)♦
61st thru 90th	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
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			

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
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 \$(83.75) a day	Up to \$(83.75) a day ♦
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	50%	50%♦
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance♦

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

PLAN K

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

****Once you have been billed \$(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.

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 med			

Regulations of Connecticut State Agencies

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
ical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$(183) of Medicare Approved Amounts****	\$0	\$0	\$(183) (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges			All costs (and they do not count toward annual out-of-pocket limit of \$(5240))*
(Above Medicare Approved Amounts)	\$0	\$0	
BLOOD			
First 3 pints	\$0	50%	50%♦
Next \$(183) of Medicare Approved Amounts****	\$0	\$0	\$(183) (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$(5240) per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**PLAN K
PARTS A & B**

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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 \$(183) of Medicare Approved Amounts*****	\$0	\$0	\$(183) (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	10%	10%♦

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

PLAN L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$(2620) each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$(1,340)	\$(1005) (75% of Part A deductible)	\$(335) (25% of Part A deductible) ♦
61st thru 90th day	All but \$(335) a	\$(335) a day	\$0

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
	day		
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
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	All but \$(167.50) a day	Up to \$(125.64) (75% of Part A Coinsurance) a day	Up to \$(41.88) (25% of Part A Coinsurance) a day♦
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	75%	25%♦
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 copayment/coinsurance for outpatient drugs and inpatient respite	75% of copayment/coinsurance or copayments	25% of copayment/coinsurance♦

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
	care		

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

PLAN L

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

****Once you have been billed \$(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.

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 \$(183) of Medicare Approved Amounts****	\$0	\$0	\$(183) (Part B deductible)****♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
Part B Excess Charges			All costs (and they do not count toward annual out-of-pocket limit of \$(2620))*
(Above Medicare Approved Amounts)	\$0	\$0	
BLOOD			

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
First 3 pints	\$0	75%	25%♦
Next \$(183) of Medicare Approved Amounts****	\$0	\$0	\$(183) (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$(2620) per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN L

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$(183) of Medicare Approved Amounts*****	\$0	\$0	\$(183) (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	15%	5%♦

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

PLAN M

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

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

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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 \$(1,340)	\$(670) (50% of Part A deductible)	\$(670) (50% of Part A deductible)
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
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

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
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 copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

PLAN M

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

*Once you have been billed \$(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.

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 \$(183) of Medicare Approved Amounts*	\$0	\$0	\$(183) (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved)	\$0	\$0	All costs

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
Amounts)			
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$(183) of Medicare Approved Amounts*	\$0	\$0	\$(183) (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN M

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 \$(183) of Medicare Approved Amounts*	\$0	\$0	\$(183) (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN M

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
FOREIGN TRAVEL			
NOT COVERED BY MEDICARE Medically nec			

Regulations of Connecticut State Agencies

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
essary emergency care serv- ices 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 life- time maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$(1,340)	\$(1,340) (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 Eligi- ble Expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All Costs

Regulations of Connecticut State Agencies

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 \$(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 copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

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

PLAN N

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

*Once you have been billed \$(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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES—			

Regulations of Connecticut State Agencies

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
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) (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to \$(20) per office visit and up to \$(50) per emergency room visit. The copayment of up to \$(50) is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to \$(20) per office visit and up to \$(50) per emergency room visit. The copayment of up to \$(50) is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges			
(Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$(183) of Medicare Approved Amounts*	\$0	\$0	\$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORA	100%	\$0	\$0

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
TORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES			

PLAN N

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 equip- ment First \$(183) of Medicare Approved Amounts*	\$0	\$0	\$(183) (Part B Deductible)
Remainder of Medicare Ap- proved Amounts	80%	20%	\$0

PLAN N

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
FOREIGN TRAVEL			
NOT COVERED BY MEDICARE Medically nec- essary emergency care serv- ices 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 life- time maximum benefit of	20% and amounts over the \$50,000 lifetime

Regulations of Connecticut State Agencies

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
		\$50,000	maximum

(e) Notice Regarding Policies or Certificates, Which Are Not Medicare Supplement Policies.

(1) Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy, a policy issued pursuant to a contract under section 1876 of the Federal Social Security Act (42 U.S.C. section 1395 et seq.), disability income policy, or other policy identified in section 38a-495a-1 of the Regulations of Connecticut State Agencies, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. Such notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds.

Such notice shall be in no less than twelve (12) point type and shall contain the following language:

“THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CONTRACT). If you are eligible for Medicare, review the Guide to Health Insurance for people with Medicare available from the company.”

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subdivision (1) of this subsection shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

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