the voting shares of Capitol Bank, Madison, Wisconsin, a *de novo* bank.

Board of Governors of the Federal Reserve System, June 6, 1995.

Jennifer J. Johnson,

Deputy Secretary of the Board.

[FR Doc. 95–14301 Filed 6–9–95; 8:45 am]

BILLING CODE 6210–01–F

Community National Corporation; Notice of Application to Engage de novo in Permissible Nonbanking Activities

The company listed in this notice has filed an application under § 225.23(a)(1) of the Board's Regulation Y (12 CFR 225.23(a)(1)) for the Board's approval under section 4(c)(8) of the Bank Holding Company Act (12 U.S.C. 1843(c)(8)) and § 225.21(a) of Regulation Y (12 CFR 225.21(a)) to commence or to engage *de novo*, either directly or through a subsidiary, in a nonbanking activity that is listed in § 225.25 of Regulation Y as closely related to banking and permissible for bank holding companies. Unless otherwise noted, such activities will be conducted throughout the United States.

The application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether consummation of the proposal can ''reasonably be expected to produce benefits to the public, such as greater convenience, increased competition, or gains in efficiency, that outweigh possible adverse effects, such as undue concentration of resources, decreased or unfair competition, conflicts of interests, or unsound banking practices.'' Any request for a hearing on this question must be accompanied by a statement of the reasons a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute, summarizing the evidence that would be presented at a hearing, and indicating how the party commenting would be aggrieved by approval of the proposal.

Comments regarding the application must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than June 26, 1995.

A. Federal Reserve Bank of Minneapolis (James M. Lyon, Vice President) 250 Marquette Avenue, Minneapolis, Minnesota 55480:

1. Community National Corporation, Grand Forks, North Dakota; to engage *de novo* through its subsidiary Document Processing and Imaging Corporation, Grand Forks, North Dakota, in providing the entire data processing service for its affiliate, Community National Bank of Grand Forks, Grand Forks, North Dakota, and providing check imaging services for Bank and other financial institutions, pursuant to § 225.25 (b)(7) of the Board's Regulation Y. These activities will be conducted in North Dakota and Minnesota.

Board of Governors of the Federal Reserve System, June 6, 1995.

Jennifer J. Johnson,

Deputy Secretary of the Board.

[FR Doc. 95–14303 Filed 6–9–95; 8:45 am]

BILLING CODE 6210–01–F

John R. and Gwen Suderman, et al.; Change in Bank Control Notices; Acquisitions of Shares of Banks or Bank Holding Companies

The notificants listed below have applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire a bank or bank holding company. The factors that are considered in acting on the notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notices are available for immediate inspection at the Federal Reserve Bank indicated. Once the notices have been accepted for processing, they will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that notice or to the offices of the Board of Governors. Comments must be received not later than June 26, 1995.

A. Federal Reserve Bank of Kansas City (John E. Yorke, Senior Vice President) 925 Grand Avenue, Kansas City, Missouri 64198:

1. John R. and Gwen Suderman, Newton, Kansas; John R. Suderman to acquire an additional 2.57 percent, for a total of 10.49 percent; John C. Suderman Revocable Trust, John R. Suderman, successor co-trustee, to retain 19.59 percent; Elga B. Suderman Revocable Trust, John R. Suderman, successor co-trustee, to retain 7.40 percent; Gwen Suderman to acquire an additional 2.57 percent, for a total of 10.49 percent; John and Gwen Suderman to acquire .91 percent; James H. and Francis G. Suderman, James H. Suderman Revocable Trust, to acquire 3.40 percent, for a total of 13.97 percent, James H. and Francis G. Suderman, co-trustees; Francis G. Suderman Revocable Trust, to acquire an additional 3.43 percent, for a total of 14.03 percent, Francis G. and James H. Suderman, co-trustees; John C. Suderman Revocable Trust, to maintain 19.59 percent, James H. Suderman, successor co-trustee; Elga B. Suderman Revocable Trust, to retain 7.40 percent of the voting shares, James H. Suderman, successor co-trustee; of Midland Financial Corporation, Newton, Kansas, and thereby indirectly acquire Midland National Bank, Newton, Kansas.

Board of Governors of the Federal Reserve System, June 6, 1995.

Jennifer J. Johnson,

Deputy Secretary of the Board.

[FR Doc. 95–14304 Filed 6–9–95; 8:45 am]

BILLING CODE 6210–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[BPD–832–N]

Medicare Program: HHS' Approval of NAIC Statements Relating to Duplication of Medicare Benefits

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Notice.

SUMMARY: This notice contains 10 disclosure statements that have been developed by the National Association of Insurance Commissioners (NAIC) and approved by the Secretary, consistent with the requirements contained in the Social Security Act, as amended in 1994. The purpose of these statements is to inform prospective buyers of health insurance policies of the extent to which benefits under the policy duplicate Medicare benefits. Each of the 10 statements applies to a different type of health insurance policy the NAIC identified as needing a disclosure statement. As of the effective date of this notice, issuers of policies that duplicate Medicare benefits must display the applicable statement in a prominent manner as part of, or together with, the application for the policy. Issuers who fail to provide the duplication notice could be subject to penalties relating to the sale of duplicate health insurance coverage.

EFFECTIVE DATE: Health insurance policy issuers subject to this notice must comply with its provisions on and after August 11, 1995.

ADDRESSES: Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents,

P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by faxing to (202) 512–2250. The cost for each copy (in paper or microfiche form) is $8. As an alternative, you may view and photocopy the **Federal Register** document at most libraries designated as U.S. Government Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Julie Walton, (410) 966–4622.

SUPPLEMENTARY INFORMATION:

I. Background

The Medicare program covers approximately 38 million beneficiaries who are age 65 or over, are disabled, or have permanent kidney failure. The program consists of two separate but complementary insurance programs, a hospital insurance program (Part A) and a supplementary medical insurance program (Part B). Although Part A is called hospital insurance, covered benefits also include medical services furnished in skilled nursing facilities or by home health agencies and hospices.

Part B covers a wide range of medical services and supplies such as those furnished by physicians or others in connection with physicians' services, outpatient hospital services, outpatient physical and occupational therapy services, and home health services. Part B also covers other items including certain drugs and biologicals that cannot be self-administered, diagnostic x-ray and laboratory tests, purchase or rental of durable medical equipment, ambulance services, prosthetic devices, and certain medical supplies.

While the Medicare program provides extensive hospital insurance benefits and supplementary medical insurance, it was not designed to cover the total cost of providing medical care for its beneficiaries. In particular:

- Benefits under both Parts A and B are reduced by certain deductible and coinsurance amounts, for which the beneficiary is responsible.
- When beneficiaries receive covered services from physicians who do not accept assignment of their Medicare claims, the beneficiaries may also be required to pay amounts in excess of the Medicare approved amount (''excess charges''), up to a limit established under the Social Security Act (the Act).
- There are a number of items generally not covered under either of Medicare's two insurance programs, such as most outpatient prescription drugs, custodial nursing home care, dental care, and eyeglasses.

Beneficiaries are liable for all of the costs listed above and may choose to purchase additional private insurance to help pay these costs.

A. Supplements to Medicare

Because Medicare does not cover the total cost of providing medical care, approximately 75 percent of Medicare beneficiaries purchase, or have available through their own or a spouse's employment or former employment, some type of private health insurance coverage to help pay for medical expenses, services, and supplies that Medicare either does not cover or does not pay in full. This coverage includes Medicare supplemental (''Medigap'') insurance; employer group health plans based on active employment or retiree coverage; hospital indemnity insurance; nursing home or long-term care insurance; and specified disease insurance. (Throughout this notice, the terms ''Medicare supplemental policy'' and ''Medigap policy'' will be used interchangeably.)

An alternative to Medigap is enrollment in a managed care plan that has a risk or cost contract with HCFA under section 1876 of the Act or a Health Care Prepayment Plan (HCPP) agreement under section 1833 of the Act. Beneficiaries who enroll in these plans are generally covered for out-of-pocket costs associated with Medicare benefits and often receive additional benefits such as prescription drugs coverage and preventive health care services at little or no cost.

In addition to the approximately 75 percent of Medicare beneficiaries with private insurance coverage, nearly 12 percent of Medicare beneficiaries are eligible for at least some Medicaid benefits. For most of these beneficiaries, Medicaid covers their Medicare coinsurance and deductible liabilities and may also provide additional benefits that Medicare does not cover, such as long term care.

B. Federal and State Regulation of Insurance

After Medicare was enacted in 1965, a number of States enacted laws and regulations governing insurance sold to supplement Medicare. However, the scope and enforcement of these laws varied considerably. Although Federal law recognizes the States as the primary regulators of insurance, in 1980 the Congress addressed certain abuses associated with the sale of health insurance to elderly Medicare beneficiaries. On June 9, 1980, Congress enacted section 507(a) of the Social Security Disability Amendments of 1980 (Public Law 96–265) (the ''Baucus Amendment''), adding section 1882 to the Act.

In adding section 1882 to the Act, Congress recognized the progress already made by the National Association of Insurance Commissioners (NAIC) and some States in the area of Medigap regulation and chose not to alter the traditional role of the States in regulating insurance.

Created in 1871, the NAIC is the organization of the chief insurance regulatory officials from all 50 States, the District of Columbia and the four territories. It provides a forum for the development of uniform public policy where uniformity is deemed appropriate by its members. The NAIC's primary instruments of public policy are model laws, regulations, and guidelines. States are free to adopt the NAIC models in their entirety, modify them, or not adopt them at all. Federal statutory requirements, however, require all States to adopt at least the minimum standards reflected in the NAIC's ''Model Regulation to Implement the Requirements of the NAIC Medicare Supplement Minimum Standards Model Act''.

The Baucus Amendment established a voluntary program under which the Federal government would certify that Medigap policies met minimum standards established by section 1882 of the Act, although policies could still be sold even if they were not certified. It also provided that if State regulatory programs met or exceeded minimum standards, including standards established by the NAIC, Medigap policies issued in those States would be deemed to meet the Federal certification requirements, and separate Federal certification would not be available in those States. However, after hearing reports of continuing abuses in the marketplace, as part of extensive Medigap reforms contained in the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508) enacted on November 5, 1990, the Congress made the certification program mandatory for both States and issuers. The Congress continued to base the Federal standards on the NAIC model regulation for Medicare supplement policies and continued to leave enforcement to the States. The model regulation was amended on July 30, 1991, to reflect the requirements of the new statutory

provisions. By July 1992, all States had adopted standards equal to or more stringent than the 1991 NAIC model regulation for Medigap policies.

The Federal certification program applies exclusively to Medigap policies, as defined in section 1882 of the Act. State regulation, by contrast, includes a wider range of policies that might be sold to Medicare beneficiaries, including limited health benefit insurance such as indemnity, specified disease, and long term care policies. (In fact some States prohibit the sale of some types of policies that are the subject of this notice, such as specified disease policies). Section 1882 of the Act does, however, affect these policies, to the extent that they duplicate other coverage a beneficiary may have.

II. Anti-Duplication Provisions

A. Medigap Legislation Before 1990

Section 1882 of the Act contains a sanctions section that establishes criminal and civil money penalties designed to assist States and the Federal government in dealing with abuses identified in the various studies and investigations of Medigap insurance. Before OBRA '90 was enacted, penalties applied if an individual sold to a Medicare beneficiary any health insurance policy (that is, not just a Medigap policy) that was known to substantially duplicate the beneficiary's Medicare coverage or other health insurance. However, benefits that were payable without regard to the individual's other health benefit coverage were to be considered non-duplicative. Section 1882(d)(3)(C) of the Act further provided that the penalties for selling or issuing duplicative coverage did not apply to group policies or plans of employers or labor organizations.

B. The Omnibus Budget Reconciliation Act of 1990

Section 4354(a) of OBRA '90 amended section 1882(d)(3) of the Act to broaden the earlier anti-duplication provisions by making several significant changes. In section 1882(d)(3)(A) of the Act, it removed the qualifier ''substantially'' that modified ''duplicates'' in the earlier version of the Act. As a result, any amount of duplication became illegal. Section 4354(a) of OBRA '90 also deleted the original wording in section 1882(d)(3)(B) of the Act that provided that if the policy paid benefits without respect to other coverage (that is, the policy did not coordinate benefits with other coverage), it would be considered non-duplicative. Section 4354(a) of OBRA '90 also broadened the anti-duplication provisions to make it illegal to duplicate Medicaid as well as Medicare benefits or other private coverage. As amended by OBRA '90, section 1882(d)(3)(A) of the Act now made it:

> * * * unlawful for a person to sell or issue a health insurance policy to an individual entitled to benefits under part A or enrolled under part B of this title, with knowledge that such policy duplicates health benefits to which such individual is otherwise entitled [including Medicare and Medicaid or any private coverage the individual might have] * * *

Under section 1882(d)(3)(C) of the Act, employer group health plans continued to be exempt from these requirements.

While the provisions of OBRA '90 were intended to protect Medicare beneficiaries from abusive sales practices and prevent them from buying unnecessary and expensive duplicate coverage, it became apparent soon after enactment that a total prohibition against any amount of duplication of benefits, including even any incidental overlap, had the unintended effect of denying Medigap or other types of desired coverage, such as long term care insurance policies, to people who already had some coverage that would be at least partially duplicated by the new policy. This was true even in cases in which the beneficiary had good reasons for wanting to buy the additional coverage.

C. Social Security Act Amendments of 1994

The Social Security Act Amendments of 1994 (SSAA '94) (Public Law 103–432) retained, in section 1882(d)(3)(A)(i)(I) of the Act, the basic prohibition against selling or issuing to a Medicare beneficiary a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is entitled under Medicare or Medicaid. However, the new law provides an exception to this basic prohibition.

The penalties for selling a policy that duplicates Medicare or Medicaid benefits (other than a Medigap policy to an individual entitled to any Medicaid benefits) do not apply if two conditions are met. First, all benefits under the policy must be fully payable directly to, or on behalf of, the beneficiary without regard to other health benefit coverage of the individual. Second, the issuer must display in a prominent manner as part of (or together with) the application a prescribed statement disclosing the extent to which benefits payable under the policy or plan duplicate Medicare benefits. The latter requirement only applies to policies sold or issued more than 60 days after the date that the required statements are published or promulgated under the provisions established in section 171(d)(3)(D) of SSAA '94. Therefore policies issued on or after August 11, 1995 must include these disclosure statements.

Section 171(d)(3)(D) of SSAA '94 provides that if, within 90 days of the statute's enactment, the NAIC develops and submits to the Secretary a statement for each type of non-Medigap health insurance policy and the Secretary approves all the statements as meeting the requirements of SSAA '94, the statements developed by the NAIC will be the ones prescribed by the law. The statute instructs the NAIC to consult with consumer and insurance industry representatives in developing the statements. The statute also specifies that the separate types of health insurance policies that need disclosure statements include, but are not limited to, fixed cash indemnity policies and specified disease policies. The statute gives the Secretary 30 days to review and approve or disapprove all the statements submitted by the NAIC. Upon approval of these statements the statute requires the Secretary to publish the statements.

III. Implementation of SSAA '94

A. Development of Disclosure Statements

In an effort to assure that consumer and insurance industry representatives had an opportunity to provide meaningful input into the NAIC's development of the disclosure statements, the NAIC undertook the following steps:

- On November 1, 1994, a Request for Comment was mailed to over 500 representatives of consumer organizations and insurance industry representatives as well as to the program directors of the Insurance Counseling and Assistance Programs established in each State.
- A Request for Comment was also sent to all NAIC members and the person responsible for health issues in each State as well as to all members of Congress and certain congressional health staff members.
- The Fall edition of the *NAIC NEWS* and the *NAIC Senior Counseling Letter* included a short summary of the major components of section 171 of the SSAA '94 (in particular, the provisions on duplication) and solicited input from the readers. These solicitations generated 33 written comment letters providing suggestions on how the NAIC should proceed.

• On December 2, 1994, a public hearing was conducted during an NAIC meeting in New Orleans, Louisiana. Sixteen representatives of organizations provided testimony at this hearing. On December 3 and 5, 1994, additional public meetings were held to begin drafting the statements.

• On December 13, 1994, draft disclosure statements were mailed to the same persons who received the Request for Comment. This mailing asked for comment on the draft statements and announced another public meeting. This mailing generated an additional 16 comment letters.

• On January 9 and 10, 1995, public meetings were held in Washington, D.C., to solicit further input from consumer and insurance industry representatives.

• On January 12, 1995, copies of the revised disclosure statements were faxed to the participants of the January 9 and 10 meetings requesting additional input and announcing the final public meeting. An additional 5 comment letters were received.

• On January 20, 1995, a final public meeting was held in Washington, D.C., seeking additional public comment on the statements before submitting them for adoption by the Commissioners in a plenary session held on January 21.

The NAIC delivered the statements to the Secretary on January 27, 1995. The Secretary approved them on February 24, 1995.

B. Availability of Comments Received During Development of NAIC Disclosure Statements

Comments concerning the 10 disclosure statements received during the development and approval process will be available for public inspection beginning with the date of the publication of this document. They may be viewed in Room 309–G of the Department's offices at 200 Independence Avenue, SW., Washington DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890), and in Room 132 East High Rise building, 6325 Security Boulevard, Baltimore Maryland, on Monday through Friday, of each week from 8:30 a.m. to 4:00 p.m. (phone: (410) 966–5633).

C. Criminal and Civil Money Penalties

Any issuer who is required to provide the appropriate statement as part of, or together with, the application after the effective date of this notice and fails to do so, or fails to pay benefits under the policy without regard to other coverage, is subject to the imposition of the Federal criminal and/or civil penalties that are identified in section 1882(d)(3)(A) of the Act. The criminal penalties identified in this section are fines under title 18 of the U.S. Code, which could be as much as $25,000, or imprisonment of not more than 5 years, or both. In addition to or in lieu of criminal penalties, an issuer who violates these requirements could be subject to a civil money penalty of up to $25,000 per violation. In the case of violation of these requirements by any person other than the issuer (e.g., an agent), the civil money penalty per violation may not exceed $15,000.

D. Policies Not Requiring Disclosure Statements

Certain policies do not have to carry a disclosure statement.

• Policies that do not duplicate Medicare benefits, even incidentally.

(An argument has been made that a policy that coordinates benefits with Medicare (that is, does not pay otherwise covered benefits if Medicare has already paid benefits) does not ''duplicate'' Medicare within the meaning of section 1882(d)(3) of the Act. However, this interpretation would make section 1882(d)(3)(C)(ii) of the Act meaningless. The latter provision permits duplication of Medicare only if a policy makes benefits fully payable without regard to other health benefit coverage. Therefore, section 1882 (d)(3)(C)(ii) of the Act only makes sense if the policy in question has a coordination of benefits clause. In other words, the controlling factor is whether the policy provides coverage of benefits that would duplicate Medicare benefits, not whether or not it actually pays.

A question was also raised as to whether policies that pay fixed dollar amounts that are not for specific services duplicate Medicare. Section 1882(d)(3)(D)(i)(I) of the Act specifically requires the NAIC to draft statements for policies that pay ''fixed, cash benefits.'' This represents a congressional determination that these policies ''duplicate'' Medicare.)

• Life insurance policies that contain long term care riders or accelerated death benefits.

(These types of policies are not covered under the disclosure requirements for two reasons. First, they are advertised, marketed, and sold as life products, not as ''health insurance.'' Second, as life insurance policies, these products will always pay the same amount of benefit whether the payment is made before or after death. By contrast, if a long term care insurance policyholder dies without ever filing a claim for long term care benefits, there is usually no return on his or her ''investment'' in premiums.)

• Disability insurance policies.

(Although in some contexts these types of policies may be considered to be a form of health insurance, we believe that they are not the type of insurance policies Congress intended to come within the scope of this legislation. They have traditionally been considered to be a separate type of insurance, and the Internal Revenue Code treats them differently from health insurance.)

• Property and casualty policies, including personal liability and automobile insurance.

(These types of policies may pay certain health benefits, but State laws do not consider property and casualty coverage to be ''health insurance.'')

• Employer and union group health plans.

(These types of policies are exempt from the anti-duplication prohibition under section 1882(d)(3)(C)(i) of the Act and therefore do not have to meet the requirements of section 1882 (d)(3)(C)(ii) of the Act. Such plans do not need to carry disclosure statements even though they may fit one of the above categories.)

• Managed care organizations with Medicare contracts under section 1876 of the Social Security Act.

(These plans do not ''duplicate'' Medicare benefits; rather their purpose is to actually provide all covered Medicare benefits directly to enrolled beneficiaries.)

• HCPPs that provide some or all Part B benefits under an agreement with HCFA under section 1833(a) of the Act.

(As with section 1876 managed care plans, under these agreements, HCPPs provide the actual Medicare benefits; they do not duplicate Medicare.)

E. Policies Requiring Disclosure Statements

The NAIC has identified 10 separate types of health insurance policies that each need an individualized statement of the extent to which the policy duplicates Medicare. These types of policies are—

(1) policies that provide benefits for expenses incurred for an accidental injury only;

(2) policies that provide benefits for specified limited services;

(3) policies that reimburse expenses incurred for specified disease or other specified impairments (including cancer policies, specified disease policies and other policies that limit reimbursement to named medical conditions);

(4) policies that pay fixed dollar amounts for specified disease or other

specified impairments (including cancer, specified disease policies and other policies that pay a scheduled benefit or specified payment based on diagnosis of the conditions named in the policy);

(5) indemnity policies and other policies that pay a fixed dollar amount per day, excluding long term care policies;

(6) policies that provide benefits for both expenses incurred and fixed indemnity;

(7) long-term care policies providing both nursing home and non-institutional coverage;

(8) long-term care policies primarily providing nursing home benefits only;

(9) home care policies; and

(10) other health insurance policies not specifically identified above.

IV. Policy Disclosure Statements

We have reviewed and approved the statements developed by the NAIC along with the instructions for their use and they are set forth as an addendum to this notice.

V. Other

This notice was reviewed by the Office of Management and Budget.

(Section 1882(d)(3) of the Social Security Act (42 U.S.C. 1395ss(d)(3)))

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: April 17, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Addendum

Adopted by the NAIC on 1/21/95

Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries That Duplicate Medicare

1. Federal law, P.L. 103–432, prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

3. State and Federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.

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

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

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

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

BILLING CODE 4120–01–P

[For policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

Before You Buy This Insurance

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

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

Before You Buy This Insurance

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

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that reimburse expenses incurred for specified disease(s) or other specified impairment(s). This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

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

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that pay fixed dollar amounts for specified disease(s) or other specified impairment(s). This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

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

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

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

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items & services

Before You Buy This Insurance

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

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

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

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

Before You Buy This Insurance

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

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

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies providing nursing home benefits only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

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

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

Before You Buy This Insurance

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

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

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies providing home care benefits only]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

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

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

Before You Buy This Insurance

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

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

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

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

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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