Federal Register

Friday,
April 24, 2009

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicare Program; Recognition of NAIC Model Standards for Regulation of Medicare Supplemental Insurance; Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4139–N]

RIN 0938–AP62

Medicare Program; Recognition of NAIC Model Standards for Regulation of Medicare Supplemental Insurance

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces changes made by the Genetic Information Nondiscrimination Act of 2008 (GINA) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) to section 1882 of the Social Security Act (the Act), which governs Medicare supplemental insurance. This notice also recognizes that the Model Regulation adopted by the National Association of Insurance Commissioners (NAIC) on September 24, 2008, is considered to be the applicable NAIC Model Regulation for purposes of section 1882 of the Act, subject to our clarifications that are set forth in this notice.

DATES: Amendments made by GINA apply to issuers of Medigap policies for policy years beginning on or after May 21, 2009. Each State shall have up to July 1, 2009 to conform its regulatory program to the statutory changes made by GINA, and the revisions to the NAIC Model Regulation that reflect GINA. Amendments made by MIPPA apply to Medigap policies with an effective date on or after June 1, 2010. Each State shall have up to September 24, 2009 to conform its regulatory program to the statutory changes made by MIPPA and the revisions to the NAIC model law and regulations that reflect MIPPA.

FOR FURTHER INFORMATION CONTACT: Jay Dobbs, (410) 786–1182 or Adam Shaw, (410) 786–1091.

SUPPLEMENTARY INFORMATION:

I. Background

A. The Medicare Program

The Medicare program was established by the Congress in 1965 with the enactment of title XVIII of the Social Security Act (the Act). The program provides payment for certain medical expenses for persons 65 years of age or older, certain disabled individuals, and persons with end-stage renal disease.

Medicare has three types of benefits: The ''hospital insurance program'' (Part A) covers inpatient care. The ''supplementary medical insurance program'' (Part B) covers a wide range of medical services, including physicians' services and outpatient hospital services, as well as equipment and supplies, such as prosthetic devices. The ''Voluntary prescription drug benefit program'' (Part D) covers outpatient prescription drugs not otherwise covered by Part B.

Beneficiaries can get their Part A and B benefits in two ways. Under ''Original Medicare,'' beneficiaries get their Part A and Part B benefits directly from the Federal government. Beneficiaries can also choose to get their Part A and B benefits through private health plans, such as HMOs, that contract with Medicare. Most of these contracts are under Part C of Medicare, the Medicare Advantage Program.

While Medicare provides extensive benefits, it is not designed to cover the total cost of medical care for Medicare beneficiaries. Under Original Medicare, even if the items or services are covered by Medicare, beneficiaries are responsible for various deductible, coinsurance, and in some cases copayment amounts. In addition, there are medical expenses that are not covered by Medicare at all.

1. Deductibles

Under Original Medicare, a beneficiary with Part A is responsible for the Part A inpatient hospital deductible for each ''benefit period.'' A benefit period is the period beginning on the first day of hospitalization and extending until the beneficiary has not been an inpatient of a hospital or skilled nursing facility for 60 consecutive days. The inpatient hospital deductible is updated annually in accordance with a statutory formula. The inpatient hospital deductible for calendar year (CY) 2008 is $1,024. For CY 2009, it is $1,068.

A beneficiary with Part B is responsible for the Part B deductible for each calendar year. The deductible is indexed to the increase in the average cost of Part B services for aged beneficiaries. The Part B deductible is $135.00 for CY 2008 and CY 2009.

2. Coinsurance

As noted above, beneficiaries are generally responsible for paying coinsurance for covered items and services. For example, the coinsurance applicable to physicians' services under Part B is generally 20 percent of the Medicare-approved amount for the service. If a physician or certain other suppliers accept assignment, the beneficiary is only responsible for the coinsurance amount. When beneficiaries receive covered services from physicians or other suppliers who do not accept assignment of their Medicare claims, the beneficiaries may also be responsible for some amounts in excess of the Medicare approved amount (''excess charges'').

3. Noncovered Services

Some items and services are not covered under either Part A or Part B; for example, custodial nursing home care, most dental care, eyeglasses, and most prescription drugs.

Because Original Medicare covers many health care services and supplies, but beneficiaries are responsible for the out-of-pocket expenses described above, most people choose to get some type of additional coverage to pay some of the costs not covered by Original Medicare. For people who do not have coverage from a current or previous employer that performs this function, the most common coverage is Medicare supplemental insurance. Some beneficiaries may also try to defray some expenses with hospital indemnity insurance, nursing home or long term care insurance, or specified disease (for example, cancer) insurance.

B. Medicare Supplemental Insurance

A Medicare supplemental (Medigap) policy is a health insurance policy sold by private insurance companies specifically to fill ''gaps'' in Original Medicare coverage. A Medigap policy typically provides coverage for some or all of the deductible and coinsurance amounts applicable to Medicare-covered services, and sometimes covers items and services that are not covered by Medicare.

Section 1882 of the Act sets forth requirements and standards that govern the sale of Medigap policies. It incorporates by reference, as part of the statutory requirements, certain minimum standards established by the National Association of Insurance Commissioners (NAIC). These minimum standards, known as the ''NAIC Model Standards,'' are found in the ''Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act'' (NAIC Model), initially adopted by the NAIC on June 6, 1979, and revised to reflect subsequent legislative changes.

Under current provisions of section 1882 of the Act, Medigap policies generally may not be sold unless they conform to one of 14 standardized benefit packages that have been defined and designated by the NAIC. The ten original standardized plans were created pursuant to the Omnibus Budget

Reconciliation Act of 1990 (OBRA–90), and designated ''A'' through ''J''. The Balanced Budget Act of 1997 (BBA) authorized plans ''F'' and ''J'' to have high deductible options that are counted as separate plans, and the Medicare Modernization Act of 2003 (MMA) created new plans ''K'' and ''L'', bringing the total to 14. Three States (Massachusetts, Minnesota, and Wisconsin) are permitted by statute to have different standardized Medigap plans and are sometimes referred to in this context as the ''waiver'' States. There are also policies issued before the OBRA–90 requirements became applicable in 1992 (''prestandardized policies'') that are still in effect.

Effective January 1, 2006, Medigap policies can no longer be sold with a prescription drug benefit. Three of the 10 original standardized Medigap plans, ''H'', ''I'', and ''J,'' as well as some Medigap policies in the waiver States may still contain coverage for outpatient prescription drugs if the policies were sold before January 1, 2006. In addition, some pre-standardized plans cover drugs. If a beneficiary holding one of these policies enrolls in Medicare Part D prescription drug coverage, the prescription drug coverage is removed from the individual's Medigap policy.

Section 1882(b)(1) of the Act also provides that Medigap policies issued in a State are deemed to meet the Federal requirements if the State's program regulating Medicare supplemental policies provides for the application of standards at least as stringent as those contained in the NAIC Model Regulation, and if the State requirements are equal to or more stringent than those set forth in section 1882 of the Act.

States must amend their regulatory programs to implement all new Federal statutory requirements and applicable changes to the NAIC Model Standards. Thus, States will now be required to implement the statutory changes made by GINA and MIPPA, and the changes to the NAIC Model Standards made to comport with the requirements of GINA and MIPPA. The revised NAIC Model Standards are attached to this notice. While States generally cannot modify the standardized benefit packages set out in the NAIC Model, with respect to other provisions, States retain the authority to enact regulatory provisions that are more stringent than those that are incorporated in the NAIC Model Standards or in the statutory requirements (see section 1882(b)(1)(A) of the Act). States that have received a waiver under section 1882(p)(6) of the Act may continue to authorize the sale of policies that contain different benefits than the 14 standardized benefit packages. However, those States are also required to amend their regulatory programs to implement the new Federal statutory requirements and changes to the NAIC Model Standards as a result of GINA and MIPPA.

II. Legislative Changes Affecting Medigap Policies and Clarification

A. Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA was enacted on May 21, 2008 (Pub. L. 110–233). Title I of GINA amends the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act (PHS Act), the Internal Revenue Code of 1986 (Code), and the Social Security Act (SSA) to prohibit discrimination in health care coverage based on genetic information. Section 104 of GINA applies to Medicare supplemental (Medigap) coverage. The new requirements were added to section 1882 of the Act in new subsections (s)(2)(E), (s)(2)(F), and (x).

In the Medigap market, GINA prohibits issuers from denying or conditioning the issuance or effectiveness of a policy (including the imposition of any exclusion of benefits based on a preexisting condition) or discriminating in the pricing of the policy (including the adjustment of premium rates) based on an individual's genetic information. However, if otherwise permitted under title XVIII of the Act, the issuer can still impose such limitations based on a manifested disease of an individual who is covered under the policy.

GINA also generally prohibits Medigap issuers from requesting or requiring an individual or family member of an individual to undergo a genetic test. There are two exceptions. First, issuers are not precluded from obtaining and using the results of a genetic test to make a determination regarding payment, but they may only use the minimum amount of information necessary.

Second, a health insurance issuer in the Medigap market may request (but not require) an individual or family member to undergo a genetic test solely for research purposes, if specific conditions are met.

Medigap issuers are prohibited from requesting, requiring, or purchasing genetic information for underwriting purposes (as defined in GINA, see below) or prior to an individual's enrollment under a policy. Furthermore, an exception to the prohibition on requesting, requiring, or purchasing genetic information is included for genetic information which is obtained incidental to the request, requirement, or purchase of other information concerning an individual, provided it is not used for underwriting purposes.

GINA defines genetic information with respect to any individual as information about that individual's genetic tests, the genetic tests of family members of the individual, and the manifestation of a disease or disorder in family members of the individual. The term genetic information also includes an individual's request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, but does not include information about the sex or age of any individual.

Genetic services are further defined as a genetic test, genetic counseling (which includes obtaining, interpreting, or assessing genetic information), or genetic education. A genetic test is defined as an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes. The term does not include an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes, or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that a health care professional with appropriate training and expertise could reasonably detect.

The term ''family member'' is defined to include first-degree through fourth-degree relatives of an individual. Underwriting purposes are defined to include rules for, or determination of, eligibility for benefits, computation of premiums, application of pre-existing condition exclusions, and other activities related to the creation, renewal, or replacement of a policy. The statute also clarifies that references to genetic information concerning an individual include the genetic information of a fetus carried by a pregnant woman and of an embryo legally held by an individual utilizing an assisted reproductive technology.

The provisions of GINA are effective with respect to health insurance issuers in the Medigap market for policy years beginning on or after May 21, 2009. States generally must incorporate the GINA provisions into their regulatory programs no later than July 1, 2009. The GINA requirements are enumerated in Section 24 of the new September 24, 2008 Model regulation.

B. Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

MIPPA was enacted on July 15, 2008 (Pub. L. 110–275). Section 104(a) of MIPAA requires the Secretary of HHS to provide for implementation of the changes in the NAIC Model #651 (Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act) approved by the NAIC on March 11, 2007. The changes, outlined below in subsection C, are effective for Medigap policies with effective dates on or after June 1, 2010. The States have until September 24, 2009 (one year past the date the changes to the Model were adopted by the NAIC) to conform their regulatory programs to the changes to the Model made pursuant to MIPPA.

Section 104(b) of MIPAA amended section 1882(o) of the Act to require issuers of Medigap policies to make available at least Medicare supplemental policies with benefit packages classified as ''C'' or ''F'' if they wish to offer other Medigap plans in addition to the core benefit plan ''A''. Finally, section 104(c) of MIPPA provides a clarification that policies that cover out-of-pocket costs under Medicare Advantage Plans (established under Medicare Part C) must comply with the requirements of section 1882(o) of the Act. These two provisions were reflected in the Model adopted by the NAIC on September 24, 2008.

C. Changes to the NAIC Model #651 (Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act) Approved by the NAIC on March 11, 2007

Responding to a statement in the conference report for the MMA regarding the benefits of modernizing the Medigap market, the NAIC formulated a task force consisting of State regulators, consumer advocates, industry representatives, and CMS staff to draft changes to the Medigap standardized plan structure with the intent of streamlining and updating the benefits in the plans. The changes drafted by the task force were approved by the NAIC on March 11, 2007, and were authorized by MIPPA as indicated above. The new Model (with the approved changes) was adopted by the NAIC on September 24, 2008. The changes apply to Medigap plans with policy years beginning on or after June 1, 2010.

The following are the changes to the standardized Medigap plans:

- Added Hospice coverage as a Basic ''Core'' benefit to all plans, as similar coverage was added as a basic benefit in plans ''K'' and ''L''.
- Deleted coverage for Preventive and At-Home Recovery. The NAIC concluded that Medicare Part B has changed to cover many more preventive benefits, and the usefulness of this benefit in a Medigap policy was significantly reduced, covering only part of an annual physical after Medicare covered the beneficiaries' initial physical. The NAIC also concluded that the At-Home Recovery benefit was confusing and difficult to understand and administer, and changes to Medicare had made this benefit less meaningful.
- Created a new plan D, which is identical to the current plan D except that the At-Home Recovery benefit was deleted.
- Created a new plan G, which is identical to the current plan G except that the 80% Medicare Part B Excess charge benefit would be replaced by a 100% Medicare Part B Excess charge benefit, and the At-Home Recovery benefit was deleted.
- Eliminated the current ''E'', ''H'', ''I'' and ''J'' plans as they duplicated existing Plans.
- Created a new plan ''M'', which duplicates plan D but with a 50% coinsurance on the Part A deductible.
- Created a new plan ''N'' which duplicates plan D with the Part B co-insurance being paid at 100%, less a $20 co-pay per physician visit and a co-pay of $50 per emergency room visit, unless the beneficiary was admitted to the hospital.

As a result of these changes, the new Model has two sets of standardized plans: Sections 8 and 9 of the Model outline the current benefits for standardized plans with an effective date of coverage prior to June 1, 2010 (we will refer to these as the ''1990 standardized plans''); and Section 8.1 and 9.1 spell out the benefits for the standardized plans with an effective date for coverage on or after June 1, 2010 (referred to as the ''2010 standardized plans'').

D. Clarification-Upon Exhaustive Benefit

Section 8.B. of the revised NAIC Model describes the standards for basic benefits common to plans ''A'' through ''J''. Section 8.D.(1) describes the standards for benefits common to plans ''K'' through ''L''. Section 8.B.(3) and section 8.D.(1)(c) describe what is commonly referred to as the ''upon exhaustion'' benefit. Medicare provides inpatient hospital benefits for up to 90 days in a benefit period, plus any of the 60 ''lifetime reserve days'' that have not already been used. After a beneficiary exhausts this coverage, including the lifetime reserve days, all Medigap policies cover 100 percent of Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of 365 days. We note that the last sentence of section 8.B.(3) and of section 8.D.(1)(c) is not part of the benefit description of the ''upon exhaustion'' benefit. Therefore, a State's failure to include this language in its regulatory program does not affect the State's compliance with Federal Medigap standards and requirements. Similarly, section 17.D(4) of the Model sets forth all the outlines of coverage for plans ''A'' through ''K''. Each outline contains, at the bottom of its first page, a ''Notice'' to prospective purchasers. The final sentence of this notice is not part of the benefit description, and therefore a State's failure to include this language in the outlines of coverage does not affect the State's compliance with Federal Medigap standards and requirements.

III. Standardized Benefit Packages

The following is a list of the standardized Medigap benefit packages, with a cross-reference to the sections of the attached NAIC Model where the packages are described in detail. The Model Regulation, adopted by the NAIC on September 24, 2008, is reprinted at the end of this notice. The NAIC has granted permission for the NAIC Model Regulation to be published and reproduced. Under 1 CFR 2.6, there is no restriction on the republication of material as it appears in the **Federal Register.**

1990 Standardized Plans With an Effective Date of Coverage Prior to June 1, 2010.

- Plan ''A'' (Core Benefit Plan) (NAIC Model Section 9.E.(1))
- Plan ''B'' (NAIC Model Section 9.E.(2))
- Plan ''C'' (NAIC Model Section 9.E.(3))
- Plan ''D'' (NAIC Model Section 9.E.(4))
- Plan ''E'' (NAIC Model Section 9.E.(5))
- Plan ''F'' (NAIC Model Section 9.E.(6))
- Plan ''F'' High Deductible (NAIC Model Section 9.E.(7))
- Plan ''G'' (NAIC Model Section 9.E.(8))
- Plan ''H'' (NAIC Model Section 9.E.(9))
- Plan ''I'' (NAIC Model Section 9.E.(10))
- Plan ''J'' (NAIC Model Section 9.E.(11))
- Plan ''J'' High Deductible (NAIC Model Section 9.E.(12))
- Plan ''K'' (NAIC Model Section 9.F.(1))
- Plan ''L'' (NAIC Model Section 9.F.(2))

2010 Standardized Plans With an Effective Date of Coverage On or After June 1, 2010.

- Plan ''A'' (Core Benefit Plan) (NAIC Model Section 9.1.E.(1))
- Plan ''B'' (NAIC Model Section 9.1.E.(2))
- Plan ''C'' (NAIC Model Section 9.1.E.(3))
- Plan ''D'' (NAIC Model Section 9.1.E.(4))
- Plan ''F'' (NAIC Model Section 9.1.E.(5))
- Plan ''F'' High Deductible (NAIC Model Section 9.1.E.(6))
- Plan ''G'' (NAIC Model Section 9.1.E.(7))
- Plan ''K'' (NAIC Model Section 9.1.E.(8))
- Plan ''L'' (NAIC Model Section 9.1.E.(9))
- Plan ''M'' (NAIC Model Section 9.1.E.(10))
- Plan ''N'' High Deductible (NAIC Model Section 9.1.E.(11))

Authority: Sections 1882(s)(2)(E), 1882(s)(2)(F) and 1882(x) of the Social Security Act (42 U.S.C. 1395ss(s)(x)), Section 104 of Public Law 110–275.

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

Dated: March 9, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: March 25, 2009.

Charles E. Johnson,

Acting Secretary.

Revisions to Model 651

As adopted by the NAIC, September 24, 2008.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

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Section 1. Purpose

The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [cite appropriate section of state law providing authority for minimum benefit standards regulations or the NAIC Medicare Supplement Insurance Minimum Standards Model Act].

Editor's Note: Wherever the term ''commissioner'' appears, the title of the chief insurance regulatory official of the state should be inserted.

Section 3. Applicability and Scope

A. Except as otherwise specifically provided in Sections 7, 13, 14, 17 and 22, this regulation shall apply to:

(1) All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this regulation; and

(2) All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

B. This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

Section 4. Definitions

For purposes of this regulation:

A. ''Applicant'' means:

(1) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

(2) In the case of a group Medicare supplement policy, the proposed certificate holder.

B. ''Bankruptcy'' means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

C. ''Certificate'' means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

D. ''Certificate form'' means the form on which the certificate is delivered or issued for delivery by the issuer.

E. ''Continuous period of creditable coverage'' means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

F.(1) ''Creditable coverage'' means, with respect to an individual, coverage of the individual provided under any of the following:

(a) A group health plan;

(b) Health insurance coverage;

(c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);

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

(e) Chapter 55 of Title 10 United States Code (CHAMPUS);

(f) A medical care program of the Indian Health Service or of a tribal organization;

(g) A state health benefits risk pool;

(h) A health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

(i) A public health plan as defined in federal regulation; and

(j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

(2) ''Creditable coverage'' shall not include one or more, or any combination of, the following:

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

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

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

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; and

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

(3) ''Creditable coverage'' shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

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

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

(4) ''Creditable coverage'' shall not include the following benefits if offered as independent, non-coordinated benefits:

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

(b) Hospital indemnity or other fixed indemnity insurance.

(5) ''Creditable coverage'' shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

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

(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and

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

Drafting Note: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) specifically addresses separate, non-coordinated benefits in the group market at PHSA § 2721(d)(2) and the individual market at § 2791(c)(3). HIPAA also references excepted benefits at PHSA §§ 2701(c)(1), 2721(d), 2763(b) and 2791(c). In addition, creditable coverage has been addressed in an interim final rule (62 FR at 16960–16962 (April 8, 1997)) issued by the Secretary pursuant to HIPAA, and may be addressed in subsequent regulations.

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

H. ''Insolvency'' means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

Drafting Note: If the state law definition of insolvency differs from the above definition, please insert the state law definition.

I. ''Issuer'' includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

J. ''Medicare'' means the ''Health Insurance for the Aged Act,'' Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

K. ''Medicare Advantage plan'' means a plan of coverage for health benefits under Medicare Part C as defined in [refer to definition of Medicare Advantage plan in 42 U.S.C. 1395w–28(b)(1)], and includes:

(1) Coordinated care plans that provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

(2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and

(3) Medicare Advantage private fee-for-service plans.

Drafting Note: The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) redesignates ''Medicare + Choice'' as ''Medicare Advantage'' effective January 1, 2004.

L. ''Medicare supplement policy'' means a group or individual policy of [accident and sickness] insurance or a subscriber contract [of hospital and medical service associations or health maintenance organizations], other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 *et seq.*) or an issued policy under a demonstration project specified in 42 U.S.C. 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. ''Medicare supplement policy'' does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under § 1833(a)(1)(A) of the Social Security Act.

Drafting Note: Under § 104(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), policies that are advertised, marketed or designed primarily to cover out-of-pocket costs under Medicare Advantage Plans (established under Medicare Part C) must comply with the Medicare supplement requirements of § 1882(o) of the Social Security Act.

M. ''Pre-Standardized Medicare supplement benefit plan,'' ''Pre-Standardized benefit plan'' or ''Pre-Standardized plan'' means a group or individual policy of Medicare supplement insurance issued prior to [insert effective date on which the state made its revisions to conform to the Omnibus Budget Reconciliation Act of 1990].

N. ''1990 Standardized Medicare supplement benefit plan,'' ''1990 Standardized benefit plan'' or ''1990 plan'' means a group or individual policy of Medicare supplement insurance issued on or after [insert effective date of 1990 plan] and prior to June 1, 2010 and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

O. ''2010 Standardized Medicare supplement benefit plan,'' ''2010 Standardized benefit plan'' or ''2010 plan'' means a group or individual policy of Medicare supplement insurance issued on or after June 1, 2010.

P. ''Policy form'' means the form on which the policy is delivered or issued for delivery by the issuer.

Q. ''Secretary'' means the Secretary of the United States Department of Health and Human Services.

Section 5. Policy Definitions and Terms

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms that conform to the requirements of this section.

A. ''Accident,'' ''accidental injury,'' or ''accidental means'' shall be defined to employ ''result'' language and shall not include words that establish an accidental means test or use words such as ''external, violent, visible wounds'' or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: ''Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force.''

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

B. ''Benefit period'' or ''Medicare benefit period'' shall not be defined more restrictively than as defined in the Medicare program.

C. ''Convalescent nursing home,'' ''extended care facility,'' or ''skilled nursing facility'' shall not be defined more restrictively than as defined in the Medicare program.

D. ''Health care expenses'' means, for purposes of Section 14, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

E. ''Hospital'' may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

F. ''Medicare'' shall be defined in the policy and certificate. Medicare may be substantially defined as ''The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended,'' or ''Title I, Part I of Public Law 89–97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof,'' or words of similar import.

G. ''Medicare eligible expenses'' shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

H. ''Physician'' shall not be defined more restrictively than as defined in the Medicare program.

I. ''Sickness'' shall not be defined to be more restrictive than the following: ''Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.'' The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

Section 6. Policy Provisions

A. Except for permitted preexisting condition clauses as described in Section 7A(1), Section 8A(1), and Section 8.1A(1) of this regulation, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

B. No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

C. No Medicare supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by Medicare.

D. (1) Subject to Sections 7A(4), (5) and (7), and 8A(4) and (5) of this regulation, a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

(2) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

(3) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

(a) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan and;

(b) Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

Drafting Note: After December 31, 2005, MMA prohibits issuers of Medicare supplement policies from renewing outpatient prescription drug benefits for both pre-standardized and standardized Medicare supplement policyholders who enroll in Medicare Part D. Before May 15, 2006, these beneficiaries have two options: Retain their current plan with outpatient prescription drug coverage removed and premiums adjusted appropriately; or enroll in a different policy as guaranteed for beneficiaries affected by these changes mandated by MMA and outlined in Section 12, ''Guaranteed Issue for Eligible Persons.'' After May 15, 2006 however, these beneficiaries will only retain a right to keep their original policies, stripped of outpatient prescription drug coverage, and lose the right to guaranteed issue of the plans described in Section 12.

Section 7. Minimum Benefit Standards for Pre-Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery Prior to [insert effective date adopted by state]

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

Drafting Note: This section has been retained for transitional purposes. The purpose of this section is to govern all policies issued prior to the date a state makes its revisions to conform to the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508).

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

Drafting Note: States that have adopted the NAIC Individual Accident and Sickness Insurance Minimum Standards Model Act should recognize a conflict between Section 6B of that Act and this subsection. It may be necessary to include additional language in the Minimum Standards Model Act that recognizes the applicability of this preexisting condition rule to Medicare supplement policies and certificates.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

Drafting Note: This provision was prepared so that premium changes can be made based upon the changes in policy benefits that will be necessary because of changes in Medicare benefits. States may wish to redraft this provision so as to coincide with their particular authority.

(4) A ''non-cancellable,'' ''guaranteed renewable,'' or ''non-cancellable and guaranteed renewable'' Medicare supplement policy shall not:

(a) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(b) Be cancelled or non-renewed by the issuer solely on the grounds of deterioration of health.

(5)(a) Except as authorized by the commissioner of this state, an issuer shall neither cancel nor non-renew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(b) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph (5)(d), the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

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

(ii) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Section 8.1B of this regulation.

Drafting Note: Group contracts in force prior to the effective date of the Omnibus Budget Reconciliation Act (OBRA) of 1990 may have existing contractual obligations to continue benefits contained in the group contract. This section is not intended to impair such obligations.

(c) If membership in a group is terminated, the issuer shall:

(i) Offer the certificate holder the conversion opportunities described in Subparagraph (b); or

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

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

Drafting Note: Rate increases otherwise authorized by law are not prohibited by this Paragraph (5).

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

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

B. Minimum Benefit Standards.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

(3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

(6) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$100];

(7) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

Section 8. Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued or Delivered on or After [insert effective date adopted by state] and Prior to June 1, 2010

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after [insert effective date] and prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

Drafting Note: This Section has been retained for transitional purposes. The purpose of this section is to govern policies issued subsequent to the adoption of 1990 Standardized benefit plans and prior to June 1, 2010. Standards for 2010 Standardized benefit plans issued for effective dates on or after June 1, 2010 are included in Section 8.1 of this regulation.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than

six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

Drafting Note: States that have adopted the NAIC Individual Accident and Sickness Insurance Minimum Standards Model Act should recognize a conflict between Section 6B of that Act and this subsection. It may be necessary to include additional language in the Minimum Standards Model Act that recognizes the applicability of this preexisting condition rule to Medicare supplement policies and certificates.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

Drafting Note: This provision was prepared so that premium changes can be made based on the changes in policy benefits that will be necessary because of changes in Medicare benefits. States may wish to redraft this provision to conform to their particular authority.

(4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable.

(a) The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.

(b) The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.

(c) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8A(5)(e), the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder)

(i) Provides for continuation of the benefits contained in the group policy, or

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

(d) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall

(i) Offer the certificate holder the conversion opportunity described in Section 8A(5)(c), or

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

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

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

Drafting Note: Rate increases otherwise authorized by law are not prohibited by this Paragraph (5).

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

(7)(a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

(b) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(c) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.

Drafting Note: The Ticket to Work and Work Incentives Improvement Act failed to provide for payment of the policy premiums in order to reinstitute coverage retroactively. States should consider adding the following language at the end of the last sentence in Subparagraph (c): ''and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.'' This addition will clarify that issuers are entitled to collect the premium in this situation, as they are under Subparagraph (b). Also, the Ticket to Work and Work Incentives Improvement Act of 1999 does not specify the period of time that a policy may be suspended under Section 8A(7)(c). In the event that the Centers for Medicare & Medicaid Services (CMS) provides states with guidance on this issue, the phrase ''for any period that may be provided by federal law'' has been inserted into this provision in parentheses so that any time period prescribed is incorporated by reference.

(d) Reinstitution of coverages as described in Subparagraphs (b) and (c):

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

(ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare

Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

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

(8) If an issuer makes a written offer to the Medicare Supplement policyholders or certificate holders of one or more of its plans, to exchange during a specified period from his or her [1990 Standardized plan] (as described in Section 9 of this regulation) to a [2010 Standardized plan] (as described in Section 9.1 of this regulation), the offer and subsequent exchange shall comply with the following requirements:

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

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

(c) An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged [1990 Standardized] policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six (6) months to any added benefits contained in the new [2010 Standardized] policy or certificate not contained in the exchanged policy.

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

Drafting Note: The options an issuer may offer its policyholders or certificate holders may be (a) to only selected existing Plans or (b) to only certain new Plans for a particular existing Plan. For example, an exchange of a new Plan F for an old Plan F is an acceptable option. An offer to only policyholders with existing Plans with no reduction in benefits is also acceptable.

B. Standards for Basic (Core) Benefits Common to Benefit Plans A to J. Every issuer shall make available a policy or certificate including only the following basic ''core'' package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

Drafting Note: The issuer is required to pay whatever amount Medicare would have paid as if Medicare was covering the hospitalization. The ''or other appropriate Medicare standard of payment'' provision means the manner in which Medicare would have paid. The issuer stands in the place of Medicare, and so the provider must accept the issuer's payment as payment in full. The Outline of Coverage specifies that the beneficiary will pay ''$0,'' and the provider cannot balance bill the insured.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

Drafting Note: In all cases involving hospital outpatient department services paid under a prospective payment system, the issuer is required to pay the co-payment amount established by CMS, which will be either the amount established for the Ambulatory Payment Classification (APC) group, or a provider-elected reduced co-payment amount.

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans ''B'' through ''J'' only as provided by Section 9 of this regulation.

(1) Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(3) Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(7) Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(8) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for

eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, ''emergency care'' shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9)(a) Preventive Medical Care Benefit: Coverage for the following preventive health services not covered by Medicare:

(i) An annual clinical preventive medical history and physical examination that may include tests and services from Subparagraph (b) and patient education to address preventive health care measures;

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

(b) Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

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

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

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

(iii) ''Home'' shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) ''At-home recovery visit'' means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four-hour period of services provided by a care provider is one visit.

(b) Coverage Requirements and Limitations.

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

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

(iii) Coverage is limited to:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(II) The actual charges for each visit up to a maximum reimbursement of $40 per visit;

(III) $1,600 per calendar year;

(IV) Seven (7) visits in any one week;

(V) Care furnished on a visiting basis in the insured's home;

(VI) Services provided by a care provider as defined in this section;

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

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

(c) Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and

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

Drafting Note: The Omnibus Budget Reconciliation Act 1990, 42 U.S.C. 1395ss(p)(7), does not prohibit the issuers of Medicare supplement policies, through an arrangement with a vendor for discounts from the vendor, from making available discounts from the vendor to the policyholder or certificate holder for the purchase of items or services not covered under its Medicare supplement policies (for example: discounts on hearing aids or eyeglasses).

Drafting Note: The NAIC discussed including inflation protection for at-home recovery benefits, and preventive care benefits. However, because of the lack of an appropriate mechanism for indexing these benefits, NAIC has not included indexing at this point in time. However, NAIC is committed to evaluating the effectiveness of these benefits without inflation protection, and will revisit the issue. NAIC has determined that OBRA does not authorize NAIC to delegate the authority for indexing these benefits to a federal agency without an amendment to federal law.

D. Standards for Plans K and L.

(1) Standardized Medicare supplement benefit plan ''K'' shall consist of the following:

(a) Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(b) Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (j);

(e) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (j);

(f) Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph (j);

(g) Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket

limitation is met as described in Subparagraph (j);

(h) Except for coverage provided in Subparagraph (i) below, coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph (j) below;

(i) Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(2) Standardized Medicare supplement benefit plan ''L'' shall consist of the following:

(a) The benefits described in Paragraphs (1)(a), (b), (c) and (i);

(b) The benefit described in Paragraphs (1)(d), (e), (f), (g) and (h), but substituting seventy-five percent (75%) for fifty percent (50%); and

(c) The benefit described in Paragraph (1)(j), but substituting $2000 for $4000.

Section 8.1 Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After June 1, 2010

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any [1990 Standardized Medicare supplement benefit plan] for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of [—insert proper citation—].

Drafting Note: Each state should insert the proper citation(s) to its statutes or rules that govern Medicare supplement insurance policies and certificates issued prior to the June 1, 2010 effective date of 2010 Standardized benefit plan standards found in Sections 8.1 and 9.1 of this regulation. It is recommended that each state's applicable statutes or rules for Medicare supplement policies and certificates issued prior to June 1, 2010 be retained and that this section of the regulation be adopted in its entirety as a new section to govern policies issued on and after June 1, 2010.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

Drafting Note: States that have adopted the NAIC Individual Accident and Sickness Insurance Minimum Standards Model Act should recognize a conflict between Section 6B of that Act and this Subsection. It may be necessary to include additional language in the Minimum Standards Model Act that recognizes the applicability of this preexisting condition rule to Medicare supplement policies and certificates.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

Drafting Note: This provision was prepared so that premium changes can be made based on the changes in policy benefits that will be necessary because of changes in Medicare benefits. States may wish to redraft this provision to conform to their particular authority.

(4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable.

(a) The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.

(b) The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.

(c) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8.1A(5)(e) of this regulation, the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder):

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

(ii) Provides for benefits that otherwise meet the requirements of this Subsection.

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

(i) Offer the certificate holder the conversion opportunity described in Section 8.1A(5)(c) of this regulation; or

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

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

Drafting Note: Rate increases otherwise authorized by law are not prohibited by this Paragraph (5).

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

(7)(a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but

only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

(b) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(c) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.

Drafting Note: The Ticket to Work and Work Incentives Improvement Act failed to provide for payment of the policy premiums in order to reinstitute coverage retroactively. States should consider adding the following language at the end of the last sentence in Subparagraph (c): ''and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.'' This addition will clarify that issuers are entitled to collect the premium in this situation, as they are under Subparagraph (b). Also, the Ticket to Work and Work Incentives Improvement Act of 1999 does not specify the period of time that a policy may be suspended under Section 8A(7)(c). In the period that may event that the Centers for Medicare & Medicaid Services (CMS) provides states with guidance on this issue, the phrase ''for any be provided by federal law'' has been inserted into this provision in parentheses so that any time period prescribed is incorporated by reference.

(d) Reinstitution of coverages as described in Subparagraphs (b) and (c):

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

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

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

B. Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic ''core'' package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

Drafting Note: The issuer is required to pay whatever amount Medicare would have paid as if Medicare was covering the hospitalization. The ''or other appropriate Medicare standard of payment'' provision means the manner in which Medicare would have paid. The issuer stands in the place of Medicare, and so the provider must accept the issuer's payment as payment in full. The Outline of Coverage specifies that the beneficiary will pay ''$0,'' and the provider cannot balance bill the insured.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

(6) Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

Drafting Note: In all cases involving hospital outpatient department services paid under a prospective payment system, the issuer is required to pay the co-payment amount established by CMS, which will be either the amount established for the Ambulatory Payment Classification (APC) group, or a provider-elected reduced co-payment amount.

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by Section 9.1 of this regulation.

Drafting Note: Benefits for Plans K and L are set by The Medicare Prescription Drug, Improvement and Modernization. Act of 2003, and can be found in Sections 9.1E(8) and (9) of this regulation.

(1) Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

(3) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(4) Medicare Part B Deductible: Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United

States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, ''emergency care'' shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

Drafting Note: The Omnibus Budget Reconciliation Act 1990, 42 U.S.C. 1395ss(p)(7), does not prohibit the issuers of Medicare supplement policies, through an arrangement with a vendor for discounts from the vendor, from making available discounts from the vendor to the policyholder or certificate holder for the purchase of items or services not covered under its Medicare supplement policies (for example: discounts on hearing aids or eyeglasses).

Drafting Note: The descriptions of Plans K and L are contained in Section 9.1E(8) and (9) of this regulation.

Section 9. Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After [insert effective date adopted by state] and Prior to June 1, 2010

Drafting Note: This section has been retained for transitional purposes. The purpose of this Section is to govern policies issued subsequent to the adoption of 1990 Standardized benefit plans and prior to June 1, 2010. Standards for 2010 Standardized benefit plans issued for effective dates on or after June 1, 2010 are included in Section 9.1 of this regulation.

A. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in Section 8B of this regulation.

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Section 9G and in Section 10 of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans ''A'' through ''L'' listed in this subsection and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 8B and 8C, or 8D and list the benefits in the order shown in this subsection. For purposes of this section, ''structure, language, and format'' means style, arrangement and overall content of a benefit.

D. An issuer may use, in addition to the benefit plan designations required in Subsection C, other designations to the extent permitted by law.

Drafting Note: It is anticipated that if a state determines that it will authorize the sale of only some of these benefit plans, the letter codes used in this regulation will be preserved. The *Guide to Health Insurance for People with Medicare* published jointly by the NAIC and CMS will contain a chart comparing the possible combinations. In order for consumers to compare specific policy choices, it will be important that a uniform ''naming'' system be used. Thus, if only plans ''A,'' ''B,'' ''D,'' ''F (including F with a high deductible)'' and ''H'' (for example) are authorized in a state, these plans should retain these alphabetical designations. However, an issuer may use, in addition to these alphabetical designations, other designations as provided in Section 9D of this regulation.

E. Make-up of benefit plans:

(1) Standardized Medicare supplement benefit plan ''A'' shall be limited to the basic (core) benefits common to all benefit plans, as defined in Section 8B of this regulation.

(2) Standardized Medicare supplement benefit plan ''B'' shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible as defined in Section 8C(1).

(3) Standardized Medicare supplement benefit plan ''C'' shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3) and (8) respectively.

(4) Standardized Medicare supplement benefit plan ''D'' shall include only the following: The core benefit (as defined in Section 8B of this regulation), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in an foreign country and the at-home recovery benefit as defined in Sections 8C(1), (2), (8) and (10) respectively.

(5) Standardized Medicare supplement benefit plan ''E'' shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in Sections 8C(1), (2), (8) and (9) respectively.

(6) Standardized Medicare supplement benefit plan ''F'' shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100 percent) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3), (5) and (8) respectively.

(7) Standardized Medicare supplement benefit high deductible plan ''F'' shall include only the following: 100 percent of covered expenses following the payment of the annual high deductible plan ''F'' deductible. The covered expenses include the core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3), (5) and (8) respectively. The annual high deductible plan ''F'' deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan ''F'' policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan ''F'' deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(8) Standardized Medicare supplement benefit plan ''G'' shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in Sections 8C(1), (2), (4), (8) and (10) respectively.

(9) Standardized Medicare supplement benefit plan ''H'' shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (6) and (8) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(10) Standardized Medicare supplement benefit plan ''I'' shall consist of only the following: The core

benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in Sections 8C(1), (2), (5), (6), (8) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(11) Standardized Medicare supplement benefit plan ''J'' shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in Sections 8C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(12) Standardized Medicare supplement benefit high deductible plan ''J'' shall consist of only the following: 100 percent of covered expenses following the payment of the annual high deductible plan ''J'' deductible. The covered expenses include the core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in Sections 8C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The annual high deductible plan ''J'' deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan ''J'' policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

F. Make-up of two Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA);

(1) Standardized Medicare supplement benefit plan ''K'' shall consist of only those benefits described in Section 8D(1).

(2) Standardized Medicare supplement benefit plan ''L'' shall consist of only those benefits described in Section 8D(2).

G. New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

Drafting Note: Use of new or innovative benefits may be appropriate to add coverage or access if they offer uniquely different or significantly expanded coverage.

Drafting Note A state may determine by statute or regulation which of the above benefit plans may be sold in that state. The core benefit plan must be made available by all issuers. Therefore, the core benefit plan must be one of the authorized benefit plans adopted by a state. In no event, however, may a state authorize the sale of more than 10 standardized Medicare supplement benefit plans (that is, 9 plus the core policy), plus the two (2) high deductible plans, and the two (2) benefit plans K and L, mandated by MMA at the same time. Further, the modified versions of plans H, I, J as required by MMA after December 31, 2005 will not count as additional plans toward the limitations on the total number of plans discussed above.

Drafting Note: The Omnibus Budget Reconciliation Act of 1990 preempts state mandated benefits in Medicare supplement policies or certificates, except for those states which have been granted a waiver for non-standardized plans.

Drafting Note: After December 31, 2005, MMA prohibits Medicare supplement issuers from offering policies with outpatient prescription drug coverage, and from renewing outpatient prescription drug coverage for insureds enrolled in Medicare Part D. Consequently, plans with an outpatient prescription drug benefit will not be offered to new enrollees after that time.

Drafting Note: Pursuant to the enactment of MMA, two new benefit packages, called K and L, were added to plans A through J. The two new packages have higher co-payments and coinsurance contributions from the Medicare beneficiary.

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

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of [-insert proper citation-].

Drafting Note. Each state should insert the proper citation(s) to its statutes or rules that govern Medicare supplement insurance policies and certificates issued prior to the June 1, 2010 effective date of the 2010 Standardized benefit plan standards found in Sections 8.1 and 9.1 of this regulation. It is recommended that each state's applicable statutes or rules for Medicare supplement benefit plans for policies and certificates issued prior to June 1, 2010 be retained and that this section of the Model be adopted in its entirety as a new section to govern policies and certificates issued on and after June 1, 2010. (The benefit plan standards of the Medicare Supplement Model Regulation for policies issued prior to June 1, 2010 are found in Section 9 of this regulation.)

A. (1) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in Section 8.1B of this regulation.

(2) If an issuer makes available any of the additional benefits described in Section 8.1C, or offers standardized benefit Plans K or L (as described in Sections 9.1E(8) and (9) of this regulation), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in subsection A(1) above, a policy form or certificate form containing either standardized benefit Plan C (as described in Section 9.1E(3) of this regulation) or standardized benefit Plan F (as described in 9.1E(5) of this regulation).

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this Section shall be offered for sale in this state, except as may be permitted in Section 9.1F and in Section 10 of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this Subsection and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 8.1B and 8.1C of this regulation; or, in the case of plans K or L, in Sections 9.1E(8) or (9) of this regulation and list the benefits in the order shown. For purposes of this Section, ''structure, language, and format'' means style, arrangement and overall content of a benefit.

D. In addition to the benefit plan designations required in Subsection C of this section, an issuer may use other designations to the extent permitted by law.

Drafting Note: It is anticipated that if a state determines that it will authorize the sale of only some of these benefit plans, the letter codes used in this regulation will be preserved. The *Guide to Health Insurance for People with Medicare* published jointly by the NAIC and CMS will contain a chart comparing the possible combinations. In order for consumers to compare specific policy choices, it will be important that a uniform ''naming'' system be used. Thus, if only Plans A, B, D, F, F with High Deductible, and K (for example) are authorized in a state, these plans must retain their alphabetical designations. An issuer may use, in addition to these alphabetical designations, other designations as provided in Section 9.1D of this regulation.

E. Make-up of 2010 Standardized Benefit Plans:

(1) Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in Section 8.1B of this regulation.

(2) Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible as defined in Section 8.1C(1) of this regulation.

(3) Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), and (6) of this regulation, respectively.

(4) Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit (as defined in Section 8.1B of this regulation), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), and (6) of this regulation, respectively.

(5) Standardized Medicare supplement [regular] Plan F shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), (5), and (6), respectively.

(6) Standardized Medicare supplement Plan F With High Deductible shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in Subparagraph (b).

(a) The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), (5), and (6) of this regulation, respectively.

(b) The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by [regular] Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

(7) Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (5), and (6), respectively.

(8) Standardized Medicare supplement Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(a) Part A Hospital Coinsurance 61st through 90th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(b) Part A Hospital Coinsurance, 91st through 150th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(c) Part A Hospitalization After 150 Days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (j);

(e) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (j);

(f) Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph (j);

(g) Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket

limitation is met as described in Subparagraph (j);

(h) Part B Cost Sharing: Except for coverage provided in Subparagraph (i), coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph (j);

(i) Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(9) Standardized Medicare supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(a) The benefits described in Paragraphs 9.1E(8)(a), (b), (c) and (i);

(b) The benefit described in Paragraphs 9.1E(8)(d), (e), (f), (g) and (h), but substituting seventy-five percent (75%) for fifty percent (50%); and

(c) The benefit described in Paragraph 9.1E(8)(j), but substituting $2000 for $4000.

(10) Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(2), (3) and (6) of this regulation, respectively.

(11) Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3) and (6) of this regulation, respectively, with co-payments in the following amounts:

(a) the lesser of twenty dollars ($20) or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit (including visits to medical specialists); and

(b) the lesser of fifty dollars ($50) or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

Drafting Note: The NAIC expects to periodically review the co-payment levels for Medicare supplement Plan N and make adjustments to this regulation as necessary.

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

Drafting Note: Recognizing the challenge in maintaining standardization while ensuring availability of new or innovative benefits, the drafters have included additional guidance to states in the NAIC Medicare Supplement Insurance Model Regulation Compliance Manual. This guidance includes a recommendation that states consider making publicly available all approved new or innovative benefits, and requests states to report the approval of all new or innovative benefits to the NAIC Senior Issues Task Force, who will maintain a record of these benefits for use by regulators and others. The Senior Issues Task Force will periodically review state approved benefits and consider whether to recommend that they be made part of standard benefit plan designs in this regulation.

Drafting Note: A state may determine by statute or regulation which of the above benefit plans may be sold in that state. Plan A, which consists of the basic (core) benefits must be made available by all issuers. Therefore, Plan A must be one of the authorized benefit plans adopted by a state. If an issuer offers any benefit plan in addition to Plan A, then the issuer must also offer either Plan C or Plan F. Therefore, if any benefit plan is authorized by a state other than Plan A, then either Plan C or Plan F must be among the authorized benefit plans adopted by a state. Except where a new or innovative benefit is approved by the [commissioner] for sale in a state, a state may not authorize the sale of any Medicare supplement plan other than the standardized Medicare supplement benefit plans (that is, Plans A, B, C, D, F, F With High Deductible, G, K, L, M and N) set forth in this regulation.

Drafting Note: The Omnibus Budget Reconciliation Act of 1990 preempts state mandated benefits in Medicare supplement policies or certificates, except for those states which have been granted a waiver for non-standardized plans.

Section 10. Medicare Select Policies and Certificates

A. (1) This section shall apply to Medicare Select policies and certificates, as defined in this section.

Drafting Note: This section should be adopted by all states approving Medicare Select policies.

(2) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

B. For the purposes of this section:

(1) ''Complaint'' means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) ''Grievance'' means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(3) ''Medicare Select issuer'' means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(4) ''Medicare Select policy'' or ''Medicare Select certificate'' mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

(5) ''Network provider'' means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

(6) ''Restricted network provision'' means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) ''Service area'' means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

C. The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the commissioner finds that the issuer has satisfied all of the requirements of this regulation.

D. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the commissioner.

E. A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(a) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(b) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) To deliver adequately all services that are subject to a restricted network provision; or

(ii) To make appropriate referrals.

(c) There are written agreements with network providers describing specific responsibilities.

(d) Emergency care is available twenty-four (24) hours per day and seven (7) days per week.

(e) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) A statement or map providing a clear description of the service area.

(3) A description of the grievance procedure to be utilized.

(4) A description of the quality assurance program, including:

(a) The formal organizational structure;

(b) The written criteria for selection, retention and removal of network providers; and

(c) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(5) A list and description, by specialty, of the network providers.

(6) Copies of the written information proposed to be used by the issuer to comply with Subsection I.

(7) Any other information requested by the commissioner.

F. (1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing the changes. Changes shall be considered approved by the commissioner after thirty (30) days unless specifically disapproved.

(2) An updated list of network providers shall be filed with the commissioner at least quarterly.

G. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

(1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

(2) It is not reasonable to obtain services through a network provider.

H. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

I. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(a) Other Medicare supplement policies or certificates offered by the issuer; and

(b) Other Medicare Select policies or certificates.

(2) A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

(3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L.

(4) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(5) A description of limitations on referrals to restricted network providers and to other providers.

(6) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

(7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.

J. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection I of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

K. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 31st to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

L. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

M. (1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and

which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

N. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

O. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

Section 11. Open Enrollment

A. An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

B. (1) If an applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

Drafting Note: The Secretary has developed regulations pursuant to HIPAA regarding methods of counting creditable coverage, which govern the way the reduction is to be applied in Section 11B(2).

C. Except as provided in Subsection B and Sections 12 and 23, Subsection A shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

Section 12. Guaranteed Issue for Eligible Persons

A. Guaranteed Issue.

(1) Eligible persons are those individuals described in Subsection B who seek to enroll under the policy during the period specified in Subsection C, and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection E that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

B. Eligible Persons. An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

Drafting Note: Paragraph (1) above uses the federal legislative language from the Balanced Budget Act of 1997 (Pub L. 105–33) that defines an eligible person as an individual with respect to whom an employee welfare benefit plan terminates, or ceases to provide ''all'' health benefits that supplement Medicare. There was protracted discussion among the drafters about the interpretation of ''all'' in this context: if the employer drops some supplemental benefits, but not all such benefits, from its welfare plan, should the individual be eligible for a guaranteed issue Medicare supplement product? This question may become crucial to certain individuals depending on the benefits dropped by the employer. Federal legislative history appears to indicate the intention that the word ''all'' be strictly construed so as to require termination or cessation of all supplemental health benefits. States, however, can provide greater protections to beneficiaries and may wish to include, as eligible persons, individuals who have lost ''some or all'' or ''substantially all'' of their supplemental health benefits, to encompass situations where a change is made in an employee welfare benefit plan that reduces the amount of supplemental health benefits available to the individual. States that consider alternative language are reminded to consider the impact of issues such as plan changes that result in adverse selection, duplicate coverage, triggering the requirement for plan administrator notice (see Section 12D) and other issues.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social

Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(a) The certification of the organization or plan has been terminated;

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

(c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area;

(d) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

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

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

(e) The individual meets such other exceptional conditions as the Secretary may provide.

(3)(a) The individual is enrolled with:

(i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);

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

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

(iv) An organization under a Medicare Select policy; and

(b) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 12B(2).

Drafting Note: Paragraph (3)(a)(iv) above is not required if there is a provision in state law or regulation that provides for the continuation or conversion of Medicare Select policies or certificates.

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(a)(i) Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or

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

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

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

Drafting Note: The reference to ''insolvency of the issuer'' in Paragraph 4(a) above is not required if there is a provision in state law or regulation that provides for the continuation or conversion of Medicare supplement policies or certificates.

(5)(a) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act or a Medicare Select policy; and

(b) The subsequent enrollment under subparagraph (a) is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or

(6) The individual, upon first becoming eligible for benefits under part A of Medicare at age 65, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment.

(7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Subsection E(4).

Drafting Note: Federal law provides a guaranteed issue right to a Medicare supplement insurance product to individuals who enroll in Medicare Part B at age 65. States may wish to consider extending this right to other classes of individuals, such as those who postpone enrollment in Medicare Part B until after age 65 because they are working and are enrolled in a group health insurance plan.

Drafting Note: Paragraph (7) does not preclude an individual from applying for a new Medigap policy without drug coverage while still enrolled in the policy with drug coverage. The issuer will terminate the drug policy when it issues the new policy without drug coverage.

C. Guaranteed Issue Time Periods.

(1) In the case of an individual described in Subsection B(1), the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

(2) In the case of an individual described in Subsection B(2), B(3), B(5) or B(6) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;

(3) In the case of an individual described in Subsection B(4)(a), the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated;

(4) In the case of an individual described in Subsection B(2), B(4)(b), B(4)(c), B(5) or B(6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;

(5) In the case of an individual described in Subsection B(7), the

guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

(6) In the case of an individual described in Subsection B but not described in the preceding provisions of this Subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.

D. Extended Medigap Access for Interrupted Trial Periods.

(1) In the case of an individual described in Subsection B(5) (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Subsection B(5)(a) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 12B(5);

(2) In the case of an individual described in Subsection B(6) (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Subsection B(6) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 12B(6); and

(3) For purposes of Subsections B(5) and B(6), no enrollment of an individual with an organization or provider described in Subsection B(5)(a), or with a plan or in a program described in Subsection B(6), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

E. Products to Which Eligible Persons Are Entitled. The Medicare supplement policy to which eligible persons are entitled under:

(1) Section 12B(1), (2), (3) and (4) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.

(2)(a) Subject to Subparagraph (b), Section 12B(5) is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Paragraph (1);

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

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

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

(3) Section 12B(6) shall include any Medicare supplement policy offered by any issuer;

(4) Section 12B(7) is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

Drafting Note: Under federal law, for states that have an alternative form of standardization under a federal waiver and offer benefit packages other than Plans A, B, C, D, F, F with High Deductible, G, K, L, M and N, the references to benefit packages above are deemed references to comparable benefit packages offered in that state. Those states should amend the language accordingly.

F. Notification provisions.

(1) At the time of an event described in Subsection B of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection A. Such notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in Subsection B of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Section 12A. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

Drafting Note: States should ensure that educational and public information materials it develops related to Medicare include a thorough description of the rights outlined in Section 12F.

Section 13. Standards for Claims Payment

A. An issuer shall comply with section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100–203) by:

(1) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) Notifying the participating physician or supplier and the beneficiary of the payment determination;

(3) Paying the participating physician or supplier directly;

(4) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(5) Paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirements set forth in Subsection A above shall be certified on the Medicare supplement insurance experience reporting form.

Section 14. Loss Ratio Standards and Refund or Credit of Premium

A. Loss Ratio Standards.

(1) (a) A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(i) At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

(ii) At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies;

(b) Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(i) Home office and overhead costs;

(ii) Advertising costs;

(iii) Commissions and other acquisition costs;

(iv) Taxes;

(v) Capital costs;

(vi) Administrative costs; and

(vii) Claims processing costs.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(3) For purposes of applying Subsection A(1) of this section and Subsection C(3) of Section 15 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

Drafting Note: Subsection A(3) replicates language contained in the Omnibus Budget Reconciliation Act of 1990 (Pub. L. No. 101–508). It allows direct mail group policies sold on an individual basis to meet the minimum loss ratio required of individual business (65%) rather than that required of group business (75%). The NAIC eliminated this concept from this regulation in 1987 (I *Proceedings of the NAIC*, pp. 651, 673 (1988)). At that time, NAIC required direct mail group business to meet the same loss ratio requirement as other group business, regardless of whether the business was sold on an individual basis. The NAIC encourages states to apply the 75% loss ratio to all group business. Although NAIC is restricted from making revisions to its models that are not in conformance with OBRA 1990, states are free to impose more stringent requirements than OBRA.

(4) For policies issued prior to [insert effective date from Section 26 of this model, the effective date of the states regulation implementing the requirements of OBRA 1990], expected claims in relation to premiums shall meet:

(a) The originally filed anticipated loss ratio when combined with the actual experience since inception;

(b) The appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) when combined with actual experience beginning with [insert effective date of this revision] to date; and

(c) The appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) over the entire future period for which the rates are computed to provide coverage.

Drafting Note: The appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) for all group policies subject to an individual loss ratio standard when issued is 65 percent. States may amend Section 13A(4) to permit or require aggregation of closed blocks of business upon approval of CMS.

B. Refund or Credit Calculation.

(1) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) For the purposes of this section, policies or certificates issued prior to [insert effective date from Section 26 of this model, the effective date of the states regulation implementing the requirements of OBRA 1990], the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after the [insert effective date of this amendment]. The first report shall be due by May 31, [insert (effective year + 2) of this amendment].

Drafting Note: Subsection B(3) implements the requirements of Section 171 of the Social Security Act Amendments of 1994 that require a refund or credit calculation for pre-standardized Medicare supplement policies, but only for experience subsequent to the date the state amends its regulation.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a *de minimis* level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual filing of Premium Rates. An issuer of Medicare supplement policies and certificates issued before or after the effective date of [insert citation to state's regulation] in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

(1)(a) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.

(b) An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy

other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(c) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.

(2) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public Hearings. The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of [insert citation to state's regulation] if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the commissioner.

Drafting Note: This section does not in any way restrict a commissioner's statutory authority, elsewhere granted, to approve or disapprove rates.

Section 15. Filing and Approval of Policies and Certificates and Premium Rates

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

B. An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

C. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

D. (1) Except as provided in Paragraph (2) of this subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the commissioner, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(a) The inclusion of new or innovative benefits;

(b) The addition of either direct response or agent marketing methods;

(c) The addition of either guaranteed issue or underwritten coverage;

(d) The offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this section, a ''type'' means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

Drafting Note: As a result of MMA, issuers now may have H, I, and J (including J with a high deductible) both with and without outpatient prescription drug coverage. The language in Subsection D is flexible enough to allow the issuer and regulator to incorporate this factor to allow for additional policy forms.

Drafting Note: The filing of 2010 Standardized plans policy forms to take the place of 1990 Standardized plans policy forms prior to the actual withdrawal of the 1990 standardized plans policy forms should be permitted.

E. (1) Except as provided in Paragraph (1)(a), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to Subparagraph (a) shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(3) A change in the rating structure or methodology shall be considered a discontinuance under Paragraph (1) unless the issuer complies with the following requirements:

(a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(b) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential that is in the public interest.

F. (1) Except as provided in Paragraph (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in [insert citation to Section 14 of NAIC Medicare Supplement Insurance Model Regulation].

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

Drafting Note: It has come to the attention of the NAIC that the use of attained age rating in the determination of rates in Medicare supplement policies may result in situations to which a regulatory response is desirable. States should assess their Medicare supplement marketplace to determine whether a regulatory response is needed. The following provisions may be included as a new subsection to Section 15. The first option prohibits insurers from attained age rating as a methodology for setting rates. The second option does not prohibit the use of attained age rating but requires Medicare supplement insurers who do use attained age rating as a rate setting methodology to apply the age component to its rates annually. The effective date of the regulation should

provide sufficient time for insurers to re-rate approved policy forms in accordance with Section 15A and for the insurance department to approve (according to its rate filing practices and procedures), such re-ratings prior to the effective date of the regulation.

Option 1

G. An issuer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after the effective date of the amendment of this regulation based upon attained age rating as a structure or methodology.

Option 2

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

Drafting Note: State insurance regulators are encouraged to consider whether it is necessary to require issuers to file new forms where the only changes in the forms reflect year-to-year modifications in Medicare deductible and coinsurance amounts.

Section 16. Permitted Compensation Arrangements

A. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

C. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

D. For purposes of this section, ''compensation'' includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

Section 17. Required Disclosure Provisions

A. General Rules.

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The 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, the 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 certificate holder 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 CMS and in a type size no smaller than 12 point type. Delivery of the *Guide* shall be made whether or not the 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 acknowledgement 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 certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner. The 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 certificate holder 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) The 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

acknowledgement of receipt of the 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 the 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 plans 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.

BILLING CODE 4120–01–P

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

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

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

Basic Benefits:

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

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

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

***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.**

PREMIUM INFORMATION [Boldface Type]

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

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

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

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

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

RIGHT TO RETURN POLICY [Boldface Type]

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

POLICY REPLACEMENT [Boldface Type]

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

NOTICE [Boldface Type]

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

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

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

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

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

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 9.1D of this regulation.]

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$0	$[1068](Part A deductible)
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used:	$0	100% of Medicare eligible expenses	$0** All costs
—Additional 365 days	$0	$0	
—Beyond the additional 365 days			
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	All approved amounts	$0	$0
Within 30 days after leaving the hospital			
First 20 days	All but $[133.50] a day	$0	Up to $[133.50] a day
21st thru 100th day	$0	$0	All costs
101st day and after			

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 Generally 80%	$0 Generally 20%	$[135] (Part B deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs

BLOOD First 3 pints	$0	All costs	$0
Next $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

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 $[1068]	$[1068](Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used:	$0	100% of Medicare eligible expenses	$0**
—Additional 365 days	$0	$0	All costs
—Beyond the additional 365 days			
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	All approved amounts	$0	$0
First 20 days	All but $[133.50] a day	$0	Up to $[133.50] a day
21st thru 100th day	$0	$0	All costs
101st day and after			

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, F First $[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 Generally 80%	$0 Generally 20%	$[135] (Part B deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 $0 80%	All costs $0 20%	$0 $[135] (Part B deductible) $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	$0	$0	$[135] (Part B deductible)
First $[135] of Medicare Approved Amounts*	80%	20%	$0
Remainder of Medicare Approved Amounts			

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 Generally 80%	$[135] (Part B deductible) Generally 20%	$0 $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs

BLOOD First 3 pints	$0	All costs	$0
Next $[135] of Medicare Approved Amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN D

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 Generally 80%	$0 Generally 20%	$[135] (Part B deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 $0 80%	All costs $0 20%	$0 $[135] (Part B deductible) $0

CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN D

PARTS A & B

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

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	$0	$0	$250
First $250 each calendar year	$0	80% to a lifetime maxi-mum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
Remainder of charges			

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 [$2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	All approved amounts	$0	$0
First 20 days	All but $[133.50] a day	Up to $[133.50] a day	$0
21st thru 100th day	$0	$0	All costs
101st day and after			
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

(continued)

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,* *] YOU PAY

MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician's Services, inpatient and Outpatient medical and Surgical services and Supplies, physical and Speech therapy, Diagnostic tests, Durable medical Equipment, First $[135] of Medicare Approved amounts* Remainder of Medicare Approved amounts	$0 Generally 80%	$[135] (Part B deductible) Generally 20%	$0 $0
Part B excess charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $[135] of Medicare Approved amounts* Remainder of Medicare Approved amounts	$0 $0 80%	All costs $[135] (Part B deductible) 20%	$0 $0 $0

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

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

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

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN G

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

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

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

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	All approved amounts	$0	$0
First 20 days	All but $[133.50] a day	Up to $[133.50] a day	$0
21st thru 100th day	$0	$0	All costs
101st day and after			
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0

BLOOD First 3 pints	$0	All costs	$0
Next $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G

PARTS A & B

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

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	$0	$0	$250
First $250 each calendar year	$0		
Remainder of Charges		80% to a lifetime maxi-mum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN K

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*

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

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	All approved amounts.	$0	$0
First 20 days	All but $[133.50] a day	Up to $[66.75] a day	Up to $[66.75] a day ♦
21st thru 100th day	$0	$0	All costs
101st day and after			
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 co-payment/ coinsurance for outpatient drugs and inpatient respite care	50% of co-payment/ coinsurance	50% of Medicare co-payment/coinsurance♦

(continued)

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

PLAN K

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,	$0	$0	$[135] (Part B deductible)**** ♦
First $[135] of Medicare Approved Amounts****	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Preventive Benefits for Medicare covered services	Generally 80%	Generally 10%	Generally 10% ♦
Remainder of Medicare Approved Amounts			
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$4620])*
BLOOD First 3 pints	$0	50%	50%♦
Next $[135] of Medicare Approved Amounts****	$0	$0	$[135] (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

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

PLAN K

PARTS A & B

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[808.50] (75% of Part A deductible)	$[267] (25% of Part A deductible)♦
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after:		$[534] a day	
—While using 60 lifetime reserve days	All but $[534] a day		$0
—Once lifetime reserve days are used:	$0	100% of Medicare eligible expenses	$0***
—Additional 365 days		$0	
—Beyond the additional 365 days	$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	All approved amounts	$0	$0
First 20 days	All but $[133.50] a day	Up to $[100.13] a day	Up to $[33.38] a day♦
21st thru 100th day	$0	$0	All costs
101st day and after			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY***
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 co-payment/ coinsurance for outpatient drugs and inpatient respite care	75% of co-payment/ coinsurance	25% of co-payment/ coinsurance ♦

(continued)

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

PLAN L

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physi-cian's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
first $[135] of Medicare Approved Amounts****	$0	$0	$[135] (Part B deductible)**** ♦
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 (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$2310])*

BLOOD First 3 pints	$0	75%	25%♦
Next $[135] of Medicare Approved Amounts****	$0	$0	$[135] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

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

PLAN L

PARTS A & B

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

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

PLAN M

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[534](50% of Part A deductible)	$[534](50% of Part A deductible)
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used:	$0	100% of Medicare eligible expenses	$0**
—Additional 365 days		$0	All costs
—Beyond the additional 365 days	$0		
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	All approved amounts	$0	$0
First 20 days	All but $[133.50] a day	Up to $[133.50] a day	$0
21st thru 100th day	$0	$0	All costs
101st day and after			

BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

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

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

PLAN M

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	$0	$0	$[135] (Part B deductible)
—First $[135] of Medicare Approved Amounts*	Generally 80%	Generally 20%	$0
Remainder of Medicare Approved Amounts			
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

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	$0	$0	$250
First $250 each calendar year	$0	80% to a lifetime maxi-mum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
Remainder of Charges			

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

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

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

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

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.

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

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

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. § 1395 et seq.), disability income policy; or other policy identified in Section 3B of this regulation, 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. The 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. The 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 Subsection D(1) 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.

Section 18. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

[Statements]

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state

Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

[Questions]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.
[Please mark Yes or No below with an "X"]

To the best of your knowledge,

(1) (a) Did you turn age 65 in the last 6 months?

Yes____ No____

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes____ No____

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes____ No____

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes____ No____

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes____ No____

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes____ No____

(c) Was this your first time in this type of Medicare plan?

Yes____ No____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes____ No____

(4) (a) Do you have another Medicare supplement policy in force?

Yes____ No____

(b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

_____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes____ No____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes____ No____

(a) If so, with what company and what kind of policy?

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy?

START __/__/__ END __/__/__

(If you are still covered under the other policy, leave "END" blank.)

B. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five (5) years that are no longer in force.

C. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

E. The notice required by Subsection D above for an issuer shall be provided in substantially the following form in no less than twelve (12) point type:

NOTICE TO APPLICANT REGARDING REPLACMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

____ Additional benefits.

____ No change in benefits, but lower premiums.

____ Fewer benefits and lower premiums.

____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers.]

____ Other. (please specify) _____

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

(Signature of Agent, Broker or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

_____

(Applicant's Signature

_____

(Date)

*Signature not required for direct response sales.

F. Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

Section 19. Filing Requirements for Advertising

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the Commissioner of Insurance of this state for review or approval by the commissioner to the extent it may be required under state law.

Drafting Note: States should examine their existing laws regarding the filing of advertisements to determine the extent to which review or approval is required.

Section 20. Standards for Marketing

A. An issuer, directly or through its producers, shall:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

"Notice to buyer: This policy may not cover all of your medical expenses."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

(5) Establish auditable procedures for verifying compliance with this Subsection A.

B. In addition to the practices prohibited in [insert citation to state unfair trade practices act], the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

Drafting Note: Remember that the Unfair Trade Practice Act in your state applies to Medicare supplement insurance policies and certificates.

Section 21. Appropriateness of Recommended Purchase and Excessive Insurance

A. In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

C. An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

Section 22. Reporting of Multiple Policies

A. On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:

(1) Policy and certificate number; and

(2) Date of issuance.

B. The items set forth above must be grouped by individual policyholder.

Editor's Note: Appendix B contains a reporting form for compliance with this section.

Section 23. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates

A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy.

B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

Drafting Note: Although NAIC is restricted from making revisions to its models that do not conform to the Omnibus Budget Reconciliation Act of 1990, states are encouraged to consider deletion of the words "for similar benefits" in Subsection A and the words "for benefits similar to those contained in the original policy or certificate" in Subsection B. States should eliminate Paragraphs (1) and (2) (applicable to preexisting conditions) of the replacement notice required by Section 16E.

Section 24. Prohibition Against Use of Genetic Information and Requests for Genetic Testing

This Section applies to all policies with policy years beginning on or after May 21, 2009.

A. An issuer of a Medicare supplement policy or certificate;

1. shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; and

2. shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

B. Nothing in Subsection A shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from

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

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

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

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

E. For purposes of carrying out Subsection D, an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

F. Notwithstanding Subsection C, an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

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

(2) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that –

(a) compliance with the request is voluntary; and

(b) non-compliance will have no effect on enrollment status or premium or contribution amounts.

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

(4) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this Subsection, including a description of the activities conducted.

(5) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this Subsection.

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

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

I. If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of Subsection H if such request, requirement, or purchase is not in violation of Subsection G.

J. For the purposes of this Section only:

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

Drafting Note: Not all states currently regulate third-party administrators. However, the Genetic Information Nondiscrimination Act of 2008 requires that third-party administrators be included in the definition of an issuer of a Medicare supplement policy or certificate.

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

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

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

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

(6) "Underwriting purposes" means,

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

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

(c) the application of any pre-existing condition exclusion under the policy; and

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

Section 25. Separability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 26. Effective Date

This regulation shall be effective on [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1980 Proc. II 22, 26, 588, 591, 593, 595-603 (adopted).
1981 Proc. I 47, 51, 420, 422, 424, 466-447, 470-481 (amended and reprinted).
1988 Proc. I 9, 20-21, 629-630, 652-654, 668-677 (amended and reprinted).
1988 Proc. II 5, 13, 568, 601, 604, 615-624 (amended and reprinted).
1989 Proc. I 14, 813-814, 836, 4-836.26 (amended at special plenary session September 1988).
1989 Proc. I 9, 25, 703, 753-754, 757-760 (appendices amended at regular plenary session).
1990 Proc. I 6, 27-28, 477, 574-576, 580-599 (amended and reprinted).
1990 Proc. II 7, 16, 599, 656, 657 (adopted reporting form).
1992 Proc. I 12, 16-75, 1084-1085 (amended at special plenary session in July 1991).
1995 Proc. 1st Quarter 7, 12, 501, 575, 586, 592-615 (amended and most of model reprinted).
1998 Proc. 1st Quarter 769, 772-799, 905 (amended).
1998 Proc. 3rd Quarter 15, 576, 697, 701, 702-717 (amended).
2000 Proc. 2nd Quarter 21-22, 162, 273, 275-288 (amended).
2001 Proc. 2nd Quarter 13, 14, 118, 171, 176, 181-187 (amended).
2004 Proc. 3rd Quarter 84, 679-681, 747, 748-866 (amended and reprinted).
2008 Proc. 3rd Quarter (amended and reprinted).

APPENDIX A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

Line		(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues[5]		
	c. Net (for reporting purposes = 1a–1b		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		
4.	Refunds Last Year (Excluding Interest)		
5.	Previous Since Inception (Excluding Interest)		
6.	Refunds Since Inception (Excluding Interest)		
7.	Benchmark Ratio Since Inception (*see worksheet for Ratio 1*)		
8.	Experienced Ratio Since Inception (*Ratio 2*) Total Actual Incurred Claims (line 3, col. b) / Total Earned Prem. (line 3, col. a)–Refunds Since Inception (line 6)		
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10.	Tolerance Permitted (obtained from credibility table)		

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%

5,000 -9,999	5.0%
2,500 -4,999	7.5%
1,000 -2,499	10.0%
500 - 999	15.0%
If less than 500, no credibility.	

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
3 Includes Modal Loadings and Fees Charged
4 Excludes Active Life Reserves
5 This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code_____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

11.	Adjustment to Incurred Claims for Credibility Ratio 3 = Ratio 2 + Tolerance	

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.
If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims [Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6)] x Ratio 3 (line 11)	
13.	Refund = Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6) –[Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1)]	

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code_____ NAIC Company Code _____
Address _____ Person Completing Exhibit_____
Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+[6]		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans

3 Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

6 To include the earned premium for all years prior to as well as the 15th year prior to the current year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code_____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+[6]		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans

3 Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

6 To include the earned premium for all years prior to as well as the 15th year prior to the current year.

APPENDIX B

FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

APPENDIX C

DISCLOSURE STATEMENTS

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

1. Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] 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. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement 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
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- 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 [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement 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
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- 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 [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. 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
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- 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 [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. 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
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- 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 [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement 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
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- 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 [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement 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
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- 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 [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement 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
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- 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.
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[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

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.

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
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

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 [health] insurance [assistance] program [SHIP].

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[Alternative disclosure statement for policies that provide benefits for specified limited services.]

Important Notice to Persons on Medicare

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

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.

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

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

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

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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.

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
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

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.

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[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

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Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

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.

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[FR Doc. E9–9272 Filed 4–23–09; 8:45 am]

BILLING CODE 4120–01–C