3901-8-08 **Medicare supplement.**

(A) Purpose

The purpose of this rule 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 sickness and accident insurance coverage to persons eligible for medicare.

(B) Authority

This rule is promulgated pursuant to the authority vested in the superintendent under sections 3901.041, 3923.33 and 3923.331 to 3923.339 of the Revised Code.

(C) Applicability and scope

(1) Except as otherwise specifically provided in paragraphs (G), (P), (Q), (T), and (Y) of this rule, this rule ~~shall apply~~ applies to:

(a) All medicare supplement policies, delivered or issued for delivery in this state on or after the effective date of this rule; and

(b) All certificates issued under group medicare supplement policies which certificates have been delivered or issued for delivery in this state on or after the effective date of this rule.

(2) This rule ~~shall~~ does 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.

(D) Definitions

For purposes of this rule, the following terms are defined as follows:

(1) "Applicant" means, in the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits, and in the case of a group medicare supplement policy, the proposed certificate holder.

(2) "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.

(3) "Certificate" means any certificate delivered or issued for delivery in this state under a group medicare supplement policy.

(4) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(5) "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 days.

(6)

(a) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(i) A group health plan;

(ii) Health insurance coverage;

(iii) "Part A" or "Part B" of "Title XVIII of the Social Security Act" (medicare);

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

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

(vi) A medical care program of the Indian health service or of a tribal organization;

(vii) A state health benefits risk pool;

(viii) A health plan offered under chapter 89 of "Title 5 United States Code" (federal employees health benefits program);

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

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

(b) "Creditable coverage" ~~shall~~ does not include one or more, or any combination of, the following:

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

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

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

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

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

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

(c) "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;

(i) Limited scope dental or vision benefits;

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

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

(d) "Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

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

(ii) Hospital indemnity or other fixed indemnity insurance.

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

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

(ii) Coverage supplemental to the coverage provided under chapter 55 of "Title 10, United States Code"; and

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

(7) "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").

(8) "Insolvency" or "Insolvent" means:

(a) For any issuer, that it is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of either of the following:

(i) Any capital and surplus required by law for its organization;

(ii) The total par or stated value of its authorized and issued capital stock.

(b) As to any issuer licensed to do business in this state as of the effective date of sections 3903.01 to 3903.59 of the Revised Code that does not meet the standard established under paragraph (D)(8)(a) of this rule, the term "insolvency" or "insolvent" means, for a period not to exceed three years from the effective date of sections 3903.01 to 3903.59 of the Revised Code, that it is unable to pay its obligations when they are due or that its admitted assets do not exceed its liabilities plus any required capital contribution ordered by the superintendent under provisions of "Title XXXIX" of the Revised Code.

(c) For purposes of paragraph (D)(8) of this rule, "liabilities" includes, but is not limited to, reserves required by statute or by rules of the superintendent or specific requirements imposed by the superintendent upon a subject issuer at the time of admission or subsequent thereto.

(9) "Direct response issuer" means an issuer who markets medicare supplement policies or certificates without the direct involvement of an insurance agent.

(10) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans health insuring corporations, and any other entities delivering or issuing for delivery in this state medicare supplement policies or certificates.

(11) "Medicare" means the "Health Insurance for the Aged Act," "Title XVIII of the Social Security Amendments" of 1965, as then constituted or later amended.

(12) "Medicare Advantage" plan means a plan of coverage for health benefits under medicare "Part C" as defined in 42 U.S.C. 1395w-28(b)(1), and includes:

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

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

(c) "Medicare Advantage" private fee-for-service plans.

(13) "Medicare supplement policy" means a group or individual policy of sickness and accident insurance or a subscriber contract of hospital and medical service associations or health insuring corporations, 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. 1395 ss (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 section 1833(a)(1)(A) of the "Social Security Act".

(14) "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 May 1, 1992.

(15) "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 May 1, 1992 and with an effective date for coverage 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.

(16) "2010 Standardized Medicare supplement benefit plan," "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of medicare

supplement insurance with an effective date for coverage on or after June 1, 2010.

(17) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

(18) "Secretary" means the secretary of the "United States" department of health and human services.

(E) 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 such policy or certificate contains definitions or terms which conform to the requirements of paragraph (E) of this rule.

(1) "Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words which would establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(a) 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."

(b) The definition may provide that the 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.

(2) "Benefit period" or "medicare benefit period" shall not be defined more restrictively than as defined in the medicare program.

(3) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the medicare program.

(4) "Health care expenses" means, for purposes of paragraph (Q) of this rule, expenses of health insuring corporations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

(5) "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.

(6) "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.

(7) "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.

(8) "Physician" shall not be defined more restrictively than as defined in the medicare program.

(9) "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.

(F) Policy provisions

(1) Except for permitted preexisting condition clauses as described in paragraphs (G)(1)(a), (H)(1)(a), and (I)(1)(a) of this rule, 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.

(2) 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.

(3) No medicare supplement policy or certificate in force in this state shall contain benefits which duplicate benefits provided by medicare.

(4)

(a) Subject to paragraphs (G)(1)(d), (G)(1)(e), (G)(1)(g), (H)(1)(d) and (H)(1)(e) of this rule, 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.

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

(c) 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:

(i) 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;

(ii) 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.

(G) Minimum benefit standards for pre-standardized medicare supplement benefit plan policies or certificates issued for delivery prior to May 1, 1992.

No policy or certificate may be advertised, solicited or issued for delivery in this state prior to the effective date of this rule 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.

(1) General standards.

The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this rule.

(a) A medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because they 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 months before the effective date of coverage.

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

(c) 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, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

(d) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" medicare supplement policy shall not:

(i) 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

(ii) Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

(e)

(i) Except as authorized by the superintendent, an issuer shall neither cancel nor nonrenew a medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(ii) If a group medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in paragraph (G)(1)(e)(iv) of this rule, the issuer shall offer certificate holders an individual medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

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

(b) An individual medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in paragraph (I)(2) of this rule.

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

(a) Offer the certificate holder the conversion opportunities described in paragraph (G)(1)(e)(ii) of this rule; or

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

(iv) 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, such coverage to be effective the date the preceding policy terminates. 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.

(f) 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.

(g) 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 paragraph (G)(1) of this rule.

(2) Minimum benefit standards.

(a) Coverage of "Part A" medicare-eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period.

(b) Coverage for either all or none of the medicare "Part A" inpatient hospital deductible amount.

(c) Coverage of "Part A" medicare-eligible expenses incurred as daily hospital charges during use of medicare's lifetime hospital inpatient reserve days.

(d) Upon exhaustion of all medicare hospital inpatient coverage including the lifetime reserve days, coverage of at least ninety per cent of all medicare "Part A" eligible expenses for hospitalization not covered by medicare

subject to a lifetime maximum benefit of an additional three hundred sixty-five days.

(e) Coverage under medicare "Part A" for the reasonable cost of the first three 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."

(f) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment 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 [one hundred forty-seven dollars].

(g) Effective January 1, 1990, coverage under medicare "Part B" for the reasonable cost of the first three 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.

(H) Benefit standards for 1990 standardized medicare supplement benefit plan policies or certificates issued or delivered on or after May 1, 1992 and with an effective date for coverage 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 May 1, 1992 and with an effective date for coverage 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.

(1) General standards. The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this rule.

(a) A medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six 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 months before the effective date of coverage.

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

(c) 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, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes, in accordance with paragraph (R)(3)(b) of this rule.

(d) 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.

(e) Each medicare supplement policy shall be guaranteed renewable.

(i) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(ii) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(iii) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under paragraph (H)(1)(e)(v) of this rule, the issuer shall offer each certificate holder an individual medicare supplement policy which (at the option of the certificate holder)

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

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

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

(a) Offer the certificate holder the conversion opportunity described in paragraph (H)(1)(e)(iii) of this rule; or

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

(v) 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.

(vi) 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 paragraph (H)(1) of this rule.

(f) 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.

(g)

(i) 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 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 such policy or certificate within ninety days after the date the individual becomes entitled to assistance.

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

(iii) 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 certificateholder 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 the coverage within ninety days after the date of loss.

(iv) Reinstitution of such coverages described in paragraphs (H)(1)(g)(ii) and (H)(1)(g)(iii):

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

(b) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of such 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

(c) 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.

(h) 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 paragraph (J) of this rule) to a 2010 standardized plan (as described in paragraph (K) of this rule), the offer and subsequent exchange shall comply with the following requirements:

(i) An issuer need not provide justification to the superintendent 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 prefunding 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 superintendent in accordance with paragraph (R) of this rule.

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

(iii) 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 months to any added benefits contained in the new 2010 standardized policy or certificate not contained in the exchanged policy.

(iv) 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.

(2) Standards for basic ("core") benefits common to benefit plans "A" - "J"

Every issuer shall make available to each prospective insured a policy or certificate including only the following basic "core" package of benefits. 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.

(a) Coverage of "Part A" medicare-eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period;

(b) 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;

(c) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred per cent 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 three hundred sixty-five days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

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

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

(3) Standards for additional benefits. The following additional benefits shall be included in medicare supplement benefit plans "B" through "J" only as provided by paragraph (J) of this rule.

(a) Medicare "Part A" deductible: coverage for all of the medicare "Part A" inpatient hospital deductible amount per benefit period.

(b) Skilled nursing facility care: coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a medicare benefit period for post-hospital skilled nursing facility care eligible under medicare "Part A";

(c) Medicare "Part B" deductible: coverage for all of the medicare "Part B" deductible amount per calendar year regardless of hospital confinement.

(d) Eighty per cent of the medicare "Part B" excess charges: coverage for eighty per cent 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.

(e) One hundred per cent 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.

(f) Basic outpatient prescription drug benefit: coverage for fifty per cent of outpatient prescription drug charges, after a two hundred fifty dollar

calendar year deductible, to a maximum of one thousand two hundred fifty dollars 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.

(g) Extended outpatient prescription drug benefit: coverage for fifty per cent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible to a maximum of three thousand dollars 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.

(h) Medically necessary emergency care in a foreign country: coverage to the extent not covered by medicare for eighty percent 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 consecutive days of each trip outside the "United States", subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(i) 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 paragraph (H)(3)(i)(ii) of this rule 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.

Reimbursement shall be for the actual charge up to one hundred per cent 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 one hundred twenty dollars annually

under this benefit. This benefit shall not include payment for any procedure covered by medicare.

(j) 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.

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

(a) "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.

(b) "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.

(c) "Home" shall mean any place used by the insured as a place of residence, provided that such 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.

(d) "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 hours in a twenty-four hour period of services provided by a care provider is one visit.

(ii) Coverage requirements and limitations

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

(b) 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.

(c) 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 forty dollars per visit.

(iii) One thousand six hundred dollars per calendar year.

(iv) Seven 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 paragraph (H)(3)(j) of this rule.

(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 weeks after the service date of the last medicare approved home health care visit.

(iii) Coverage is excluded for:

(a) Home care visits paid for by medicare or other government programs; and

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

(4) Standards for plans "K" and "L"

(a) Standardized medicare supplement benefit plan "K" shall consist of the following:

(i) Coverage of one hundred per cent of the "Part A" hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any medicare benefit period;

(ii) Coverage of one hundred per cent of the "Part A" hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any medicare benefit period;

(iii) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred per cent 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 three hundred sixty-five days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(iv) Medicare "Plan A" deductible: coverage for fifty per cent of the medicare "Part A" inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in paragraph (H)(4)(a)(x) of this rule;

(v) Skilled nursing facility care coverage for fifty per cent of the coinsurance amount for each day used from the twenty-first day through the one hundredth 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 paragraph (H)(4)(a)(x) of this rule;

(vi) Hospice care coverage for fifty per cent of cost sharing for all "Part A" medicare-eligible expenses and respite care until the out-of-pocket limitation is met as described in paragraph (H)(4)(a)(x) of this rule;

(vii) Coverage for fifty per cent under medicare "Parts A" or "B", of the reasonable cost of the first three 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 paragraph (H)(4)(a)(x) of this rule;

(viii) Except for coverage provided in paragraph (H)(4)(a)(ix) of this rule, coverage for fifty per cent 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 paragraph (H)(4)(a)(x) of this rule:

(ix) Coverage of one hundred per cent of the cost sharing for medicare "Part B" preventive services after the policyholder pays the "Part B" deductible; and

(x) Coverage of one hundred per cent 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 four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the "United States" department of health and human services.

(b) Standardized medicare supplement benefit plan "L" shall consist of the following:

(i) The benefits described in paragraphs (H)(4)(a)(i), (H)(4)(a)(ii), (H)(4)(a)(iii), and (H)(4)(a)(ix) of this rule;

(ii) The benefit described in paragraphs (H)(4)(a)(iv), (H)(4)(a)(v), (H)(4)(a)(vi), (H)(4)(a)(vii), and (H)(4)(a)(viii) of this rule, but substituting seventy-five per cent for fifty per cent; and

(iii) The benefit described in paragraph (H)(4)(a)(x) of this rule, but substituting two thousand dollars for four thousand dollars.

(I) Benefit standards for 2010 standardized medicare supplement benefit plan policies or certificates issued or delivered with an effective date for coverage 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 with an effective date for coverage 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 the June 1, 2010 effective date of these 2010 standardized medicare supplement benefit plan standards in this state. Benefit standards applicable to medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010 remain subject to the requirements of paragraph (H) of this rule.

(1) General standards. The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this rule.

(a) A medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six 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 or received from a physician within six months before the effective date of coverage.

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

(c) 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, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

(d) 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.

(e) Each medicare supplement policy shall be guaranteed renewable.

(i) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

(ii) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(iii) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under paragraph (I)(1)(e)(5) of this rule, the issuer shall offer certificate holders an individual medicare supplement policy which (at the option of the certificate holder):

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

(b) Provides for benefits that otherwise meet the requirements of paragraph (I) of this rule.

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

(a) Offer the certificate holder the conversion opportunity described in paragraph (I)(1)(e)(3) of this rule; or

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

(v) 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) 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.

(g)

(i) 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 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 days after the date the individual becomes entitled to assistance.

(ii) 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 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(iii) 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 days after the date of the loss.

(iv) Reinstitution of coverages as described in paragraphs (I)(2) and (I)(3) of this rule:

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

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

(c) 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.

(2) 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.

(a) Coverage of "Part A" medicare-eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period;

(b) 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;

(c) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred per cent 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 three hundred sixty-five days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

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

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

(f) Hospice care: coverage of cost sharing for all "Part A" medicare eligible hospice care and respite care expenses.

(3) 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 paragraph (K) of this rule.

(a) Medicare "Part A" deductible: coverage for one hundred per cent of the medicare "Part A" inpatient hospital deductible amount per benefit period.

(b) Medicare "Part A" deductible: coverage for fifty per cent of the medicare "Part A" inpatient hospital deductible amount per benefit period.

(c) Skilled nursing facility care: coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth

day in a medicare benefit period for post-hospital skilled nursing facility care eligible under medicare "Part A."

(d) Medicare "Part B" deductible: coverage for one hundred per cent of the medicare "Part B" deductible amount per calendar year regardless of hospital confinement.

(e) One hundred per cent 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.

(f) Medically necessary emergency care in a foreign country: coverage to the extent not covered by medicare for eighty per cent 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 consecutive days of each trip outside the "United States," subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(J) Standard medicare supplement benefit plans for 1990 standardized medicare supplement benefit plan policies or certificates issued for delivery on or after May 1, 1992 and with an effective date for coverage prior to June 1, 2010.

(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 paragraph (H)(2) of this rule.

(2) No groups, packages or combinations of medicare supplement benefits other than those listed in paragraph (J) of this rule shall be offered for sale in this state, except as may be permitted in paragraphs (J) (7) and (M) of this rule.

(3) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "L" listed in paragraph (J)(5) of this rule and conform to the definitions in paragraph (D) of this rule. Each benefit shall be structured in accordance with the format provided in paragraphs (H)(2) and (H)(3), or (H)(4) of this rule and list the benefits in the order shown in paragraph (J)(5) of this rule. For purposes of this paragraph, "structure, language, and format" means style, arrangement and overall content of a benefit.

(4) An issuer may use, in addition to the benefit plan designations required in paragraph (J)(3) of this rule, other designations to the extent permitted by law.

(5) Make-up of benefit plans:

(a) Standardized medicare supplement benefit plan "A" shall be limited to the basic ("core") benefits common to all benefit plans, as defined in paragraph (H)(2) of this rule.

(b) Standardized medicare supplement benefit plan "B" shall include only the following: the core benefit as defined in paragraph (H)(2) of this rule, plus the medicare "Part A" deductible as defined in paragraph (H)(3)(a) of this rule.

(c) Standardized medicare supplement benefit plan "C" shall include only the following: the core benefit as defined in paragraph (H)(2) of this rule, 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 paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(c), and (H)(3)(h) of this rule, respectively.

(d) Standardized medicare supplement benefit plan "D" shall include only the following: the core benefit as defined in paragraph (H)(2) of this rule, plus the medicare "Part A" deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(h), and (H)(3)(j) of this rule, respectively.

(e) Standardized medicare supplement benefit [regular] plan "E" shall include only the following: the core benefit as defined in paragraph (H)(2) of this rule, 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 paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(h), and (H)(3)(i) of this rule, respectively.

(f) Standardized medicare supplement benefit plan "F" shall include only the following: the core benefit as defined in paragraph (H)(2) of this rule, plus the medicare "Part A" deductible, the skilled nursing facility care, the "Part B" deductible, one hundred per cent of the medicare "Part B" excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(c), (H)(3)(e), and (H)(3)(h) of this rule, respectively.

(g) Standardized medicare supplement benefit high deductible plan "F" shall include only the following: one hundred per cent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in paragraph (H)(2) of this rule, plus the medicare "Part A" deductible, skilled nursing facility care, the medicare "Part B" deductible, one hundred per cent of the medicare "Part B" excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(c), (H)(3)(e) and (H)(3)(h) of this rule, 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 fifteen hundred dollars 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 ten dollars.

(h) Standardized medicare supplement benefit plan "G" shall include only the following: the core benefit as defined in paragraph (H)(2) of this rule, plus the medicare "Part A" deductible, skilled nursing facility care, eighty per cent of the medicare "Part B" excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(d), (H)(3)(h), and (H)(3)(j) of this rule, respectively.

(i) Standardized medicare supplement benefit plan "H" shall consist of only the following: the core benefit as defined in paragraph (H)(2) of this rule, 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 paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(f), and (H)(3)(h) of this rule, respectively. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

(j) Standardized medicare supplement benefit plan "I" shall consist of only the following: the core benefit as defined in paragraph (H)(2) of this rule, plus the medicare "Part A" deductible, skilled nursing facility care, one hundred per cent 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 paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(e), (H)(3)(f), (H)(3)(h), and (H)(3)(j) of this

rule, respectively. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

(k) Standardized medicare supplement benefit plan "J" shall consist of only the following: the core benefit as defined in paragraph (H)(2) of this rule, plus the medicare "Part A" deductible, skilled nursing facility care, medicare "Part B" deductible, one hundred per cent 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 paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(c), (H)(3)(e), (H)(3)(g), (H)(3)(h), (H)(3)(i), and (H)(3)(j) of this rule, respectively. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

(l) Standardized medicare supplement benefit high deductible plan "J" shall consist of only the following: one hundred per cent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in paragraph (H)(2) of this rule, plus the medicare "Part A" deductible, skilled nursing facility care, medicare "Part B" deductible, one hundred per cent 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 paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(c), (H)(3)(e), (H)(3)(g), (H)(3)(h), (H)(3)(i), and (H)(3)(j) of this rule, 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 fifteen hundred dollars 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 ten dollars. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

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

(a) Standardized medicare supplement benefit plan "K" shall consist of only those benefits described in paragraph (H)(4)(a) of this rule:

(b) Standardized medicare supplement benefit plan "L" shall consist of only those benefits described in paragraph (H)(4)(b) of this rule.

(7) New or innovative benefits: an issuer may, with the prior approval of the superintendent, 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 which 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.

(K) Standard medicare supplement benefit plans for 2010 standardized medicare supplement benefit plan policies or certificates issued for delivery with an effective date for coverage 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 with an effective date for coverage 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 with an effective date for coverage before June 1, 2010 remain subject to the requirements of paragraph (J) of this rule.

(1) An issuer shall make available to each prospective policyholder and certificate holder a policy form containing only the basic (core) benefits, as defined in paragraph (I)(2) of this rule.

(2) If an issuer makes available any of the additional benefits described in paragraph (I)(3) of this rule, or offers standardized benefit plans "K" or "L" as described in paragraphs (K)(5)(h) and (K)(5)(i) of this rule, 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 the first sentence of paragraph (K) of this rule, a policy form or certificate form containing either standardized benefit plan "C" as described in paragraph (K)(5)(c) of this rule or standardized benefit plan "F" as described in paragraph (K)(5)(e) of this rule.

(3) No groups, packages or combinations of medicare supplement benefits other than those listed in this paragraph (K) of this rule shall be offered for sale in this state, except as may be provided in paragraphs (K)(7) and (M) of this rule.

(4) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this paragraph and conform to the definitions in paragraph (D) of this rule. Each benefit shall be structured in accordance with the format provided in paragraphs (I)(2) and (I)(3) of this rule; or, in the case of plans "K" or "L," in paragraph (K)(6)(h) or (K)(6)(i) of this rule and list the benefits in the order shown. For purposes of this paragraph, "structure, language, and format" means style, arrangement and overall content of a benefit.

(5) In addition to the benefit plan designations required in paragraph (K)(4) of this rule, an issuer may use other designations to the extent permitted by law.

(6) Make-up of 2010 standardized benefit plans.

(a) Standardized medicare supplement benefit plan "A" shall include only the following: the basic (core) benefits as defined in paragraph (I)(2) of this rule.

(b) Standardized medicare supplement benefit plan "B" shall include only the following: the basic (core) benefit as defined in paragraph (I)(2) of this rule, plus one hundred per cent of the medicare "Part A" deductible as defined in paragraph (I)(3)(a) of this rule.

(c) Standardized medicare supplement benefit plan "C" shall include only the following: the basic (core) benefit as defined in paragraph (I)(2) of this rule, plus one hundred per cent of the medicare "Part A" deductible, skilled nursing facility care, one hundred per cent of the medicare "Part B" deductible, and medically necessary emergency care in a foreign country as defined in paragraphs (I)(3)(a), (I)(3)(c), (I)(3)(d) and (I)(3)(f) of this rule, respectively.

(d) Standardized medicare supplement benefit plan "D" shall include only the following: the basic (core) benefit (as defined in paragraph (I)(2) of this rule), plus one hundred per cent of the medicare "Part A" deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (I)(3)(a), (I)(3)(c) and (I)(3)(f) of this rule, respectively.

(e) Standardized medicare supplement benefit [regular] plan "F" shall include only the following: the basic (core) benefit as defined in paragraph (I)(2) of this rule, plus one hundred per cent of the medicare "Part A" deductible, the skilled nursing facility care, one hundred per cent of the medicare "Part B" deductible, one hundred per cent of the medicare "Part B" excess

charges, and medically necessary emergency care in a foreign country as defined in paragraphs (I)(3)(a), (I)(3)(c), (I)(3)(d), (I)(3)(e) and (I)(3)(f) of this rule, respectively.

(f) Standardized medicare supplement plan "F With High Deductible" shall include only the following: one hundred per cent of covered expenses following the payment of the annual deductible set forth in paragraph (K)(6)(f)(ii) of this rule.

(i) The basic (core) benefit as defined in paragraph (I)(2) of this rule, plus one hundred per cent of the medicare "Part A" deductible, skilled nursing facility care, one hundred per cent of the medicare "Part B" deductible, one hundred per cent of the medicare "Part B" excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (I)(3)(a), (I)(3)(c), (I)(3)(d), (I)(3)(e) and (I)(3)(f) of this rule, respectively.

(ii) 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 one thousand five hundred dollars, and shall be adjusted annually from 1999 by the secretary of the "United States" department of health and human services to reflect the changes 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.

(g) Standardized medicare supplement benefit plan "G" shall include only the following: the basic (core) benefit as defined in paragraph (I)(2) of this rule, plus one hundred per cent of the medicare "Part A" deductible, skilled nursing facility care, one hundred per cent of the medicare "Part B" excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (I)(3)(a), (I)(3)(c), (I)(3)(e) and (I)(3)(f) of this rule, respectively. Effective January 1, 2020, the standardized benefit plans described in paragraph (L)(1)(d) of the rule (redesignated plan G high deductible) may be offered to any individual who was eligible for medicare prior to January 1, 2020.

(h) Standardized medicare supplement plan "K" is mandated by the "Medicare Prescription Drug, Improvement and Modernization Act of 2003," and shall include only the following:

(i) "Part A" hospital coinsurance, sixty-first through ninetieth days: coverage of one hundred per cent of the "Part A" hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any medicare benefit period;

(ii) "Part A" hospital coinsurance, ninety-first through one hundred fiftieth days: coverage of one hundred per cent of the "Part A" hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any medicare benefit period;

(iii) "Part A" hospitalization after lifetime reserve days are exhausted: Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred per cent 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 three hundred sixty-five days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(iv) Medicare "Part A" deductible: coverage for fifty per cent of the medicare "Part A" inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in paragraph (K)(6)(h)(x) of this rule.

(v) Skilled nursing facility care: coverage for fifty per cent of the coinsurance amount for each day used from the twenty-first day through the one hundredth 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 paragraph (K)(6)(h)(x) of this rule.

(vi) Hospice care: coverage for fifty per cent of cost sharing for all "Part A" medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in paragraph (K)(6)(h)(x) of this rule.

(vii) Blood: coverage for fifty per cent, under medicare "Part A" or "B," of the reasonable cost of the first three 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 paragraph (K)(6)(h)(x) of this rule.

(viii) "Part B" cost sharing: except for coverage provided in paragraph (K)(6)(h)(ix) of this rule, coverage for fifty per cent of the cost sharing otherwise applicable under medicare "Part B" after the policyholder pays the deductible until the out-of-pocket limitation is met as described in paragraph (K)(6)(h)(x) of this rule.

(ix) "Part B" preventive services: coverage of one hundred per cent of the cost sharing for medicare "Part B" preventive services after the policyholder pays the "Part B" deductible; and

(x) Cost sharing after out-of-pocket limits: coverage of one hundred per cent 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 four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the "United States" department of health and human services.

(i) Standardized medicare supplement plan "L" is mandated by the "Medicare Prescription Drug, Improvement and Modernization Act of 2003," and shall include only the following:

(i) The benefits described in paragraphs (K)(6)(h)(i), (K)(6)(h)(ii), (K)(6)(h)(iii) and (K)(6)(h)(ix) of this rule;

(ii) The benefit described in paragraphs (K)(6)(h)(iv), (K)(6)(h)(v), (K)(6)(h)(vi), (K)(6)(h)(vii) and (K)(6)(h)(viii) of this rule, but substituting seventy-five per cent for fifty per cent; and

(iii) The benefit described in paragraph (K)(6)(h)(x) of this rule, but substituting two thousand dollars for four thousand dollars.

(j) Standardized medicare supplement plan "M" shall include only the following: the basic (core) benefit as defined in paragraph (I)(2) of this rule, plus fifty per cent of the medicare "Part A" deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (I)(3)(b), (I)(3)(c) and (I)(3)(f) of this rule, respectively.

(k) Standardized medicare supplement plan "N" shall include only the following: the basic (core) benefit as defined in paragraph (I)(2) of this

rule, plus one hundred per cent of the medicare "Part A" deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (I)(3)(a), (I)(3)(c) and (I)(3)(f) of this rule, respectively, with copayments in the following amounts:

(i) The lesser of twenty dollars or the medicare "Part B" coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and

(ii) The lesser of fifty dollars or the medicare "Part B" coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a medicare "Part A" expense.

(7) New or innovative benefits: an issuer may, with the prior approval of the superintendent, 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.

(L) Standard medicare supplement benefit plans for year 2020 standardized medicare supplement benefit plan policies or certificates issued for delivery to individuals newly eligible for medicare on or after January 1, 2020.

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

(1) Benefit requirements. The standards and requirements of paragraph (K) of this rule shall apply to all medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for medicare on or after January 1, 2020, with the following exceptions:

(a) Standardized medicare supplement benefit plan "C" is redesignated as plan "D" and shall provide the benefits contained in paragraph (K)(6)(c) of this rule but shall not provide coverage for one hundred per cent or any portion of the medicare "Part B" deductible.

(b) Standardized medicare supplement benefit plan "F" is redesignated as plan "G" and shall provide the benefits contained in paragraph (K)(6)(e) of this rule but shall not provide coverage for one hundred per cent or any portion of the medicare "Part B" deductible.

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

(d) Standardized medicare supplement benefit "Plan F With High Deductible" is redesignated as "Plan G With High Deductible" and shall provide the benefits contained in paragraph (K)(6)(f) of this rule but shall not provide coverage for one hundred per cent or any portion of the medicare "Part B" deductible; provided further that, the medicare "Part B" deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.

(e) The reference to plan "C" or "F" contained in paragraph (K)(2) of this rule is deemed a reference to plan "D" or "G" for purposes of paragraph (L) of this rule.

(2) Applicability to certain individuals. Paragraph (L) of this rule, applies to only individuals that are newly eligible for medicare on or after January 1, 2020.

(a) By reason of attaining age sixty-five on or after January 1, 2020; or

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

(3) Guaranteed issue for eligible persons. For purposes of paragraph (O)(5) of this rule, in the case of any individual newly eligible for medicare on or after January 1, 2020, any reference to a medicare supplement policy "C" or

"F" (including "F With High Deductible") shall be deemed to be a reference to medicare supplement policy "D" or "G" (including "G With High Deductible"), respectively, that meet the requirements of paragraph (L)(1) of this rule.

(4) Offer of redesignated plans to individuals other than newly eligible. On or after January 1, 2020, the standardized benefit plans described in paragraph (L)(1)(d) of this rule, may be offered to any individual who was eligible for medicare prior to January 1, 2020, in addition to the standardized plans described in paragraph (K)(6) of this rule.

(M) Medicare select policies and certificates, as defined in this paragraph.

(1)

(a) This paragraph shall apply to medicare select policies and certificates, as defined in this paragraph.

(b) No policy or certificate may be advertised as a medicare select policy or certificate unless it meets the requirements of this paragraph.

(2) For the purposes of this paragraph:

(a) "Complaint" means any dissatisfaction expressed by an individual concerning a medicare select issuer or its network providers.

(b) "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.

(c) "Medicare select issuer" means an issuer offering, or seeking to offer, a medicare select policy or certificate.

(d) "Medicare select policy" or "medicare select certificate" mean respectively a medicare supplement policy or certificate that contains restricted network provisions.

(e) "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.

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

(g) "Service area" means the geographic area approved by the superintendent within which an issuer is authorized to offer a medicare select policy.

(3) The superintendent may authorize an issuer to offer a medicare select policy or certificate, pursuant to this paragraph and section 4358 of the "Omnibus Budget Reconciliation Act (OBRA)" of 1990 if the superintendent finds that the issuer has satisfied all of the requirements of this rule.

(4) 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 superintendent.

(5) A medicare select issuer shall file a proposed plan of operation with the superintendent in a format prescribed by the superintendent. The plan of operation shall contain at least the following information:

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

(i) 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.

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

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

(b) To make appropriate referrals.

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

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

(v) 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.

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

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

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

(i) The formal organizational structure;

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

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

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

(f) Copies of the written information proposed to be used by the issuer to comply with paragraph (M)(9) of this rule.

(g) Any other information requested by the superintendent.

(6)

(a) 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 superintendent prior to implementing such changes. Such changes shall be considered approved by the superintendent after thirty days unless specifically disapproved.

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

(7) A medicare select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

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

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

(8) 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.

(9) 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:

(a) An outline of coverage as required by paragraph (T)(4)(c) of this rule, in the form prescribed in appendix C to this rule sufficient to permit the applicant to compare coverage and premiums of the medicare select policy or certificate with:

(i) Other medicare supplement policies or certificates offered by the issuer; and

(ii) Other medicare select policies or certificates.

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

(c) 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".

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

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

(f) A description of the policyholder's right to purchase any other medicare supplement policy or certificate otherwise offered by the issuer.

(g) A description of the medicare select issuer's quality assurance program and grievance procedure.

(10) 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 paragraph (M)(9) of this rule

and that the applicant understands the restrictions of the medicare select policy or certificate.

(11) A medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

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

(b) 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.

(c) 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.

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

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

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

(12) 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.

(13)

(a) 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 such policies or certificates available without requiring evidence of insurability after the medicare select policy or certificate has been in force for six months.

(b) For the purposes of paragraph (M)(13) of this rule, 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.

(14) 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 paragraph should be discontinued due to either the failure of the medicare select program to be reauthorized under law or its substantial amendment.

(a) 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 such policies and certificates available without requiring evidence of insurability.

(b) For the purposes of paragraph (M)(14) of this rule, 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.

(15) 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.

(N) Open enrollment

(1) 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 (including tobacco or nicotine usage), 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 month period beginning with the first day of the first month in which an individual is both sixty-five years of age or older and is enrolled for benefits under medicare "Part B". Each medicare

supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under paragraph (N)(1) of this rule without regard to age.

(2)

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

(b) If the applicant qualifies under paragraph (N)(1) of this rule and submits an application during the time period referenced in paragraph (N)(1) of this rule and, as of the date of application, has had a continuous period of creditable coverage that is less than six 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 paragraph.

(3) Except as provided in paragraphs (N)(2), (O), and (Z) of this rule, paragraph (N)(1) of this rule shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

(4) In connection with the solicitation or sale of a medicare supplement policy or certificate to persons who qualify under paragraph (N)(1) of this rule, no issuer shall:

(a) Engage in any act or practice with the intent or effect of restricting the sale to or discouraging the purchase by persons eligible for open enrollment of any medicare supplement policy or certificate available in this state. Such acts or practices include but are not limited to the following:

(i) Creating a disincentive for producers to sell medicare supplement policies or certificates during the open enrollment period through compensation arrangements that reduce or eliminate compensation for sales made to persons eligible for open enrollment;

(ii) Applying waiting periods for coverage of pre-existing conditions as described in paragraph (N)(2) of this rule only to policies or certificates issued to persons eligible for open enrollment;

(iii) Engaging in premium rating practices which result in premiums which are higher for persons eligible for open enrollment than premiums for persons not eligible for open enrollment;

(iv) Failing to offer to persons eligible for open enrollment any medicare supplement policy or certificate which is available for purchase from the issuer in this state.

(O) Guaranteed issue for eligible persons

(1) Guaranteed issue

(a) Eligible persons are those individuals described in paragraph (O)(2) of this rule who seek to enroll under the policy during the period specified in paragraph (O)(2) of this rule and who submit evidence of the date of termination, disenrollment, or medicare "Part D" enrollment with the application for a medicare supplement policy.

(b) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a medicare supplement policy described in paragraph (O)(5) of this rule 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 (including tobacco or nicotine usage), 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.

(2) Eligible persons

An eligible person is an individual described in any of the following paragraphs:

(a) The individual is enrolled under an employee welfare benefit plan<u>, or a state medicaid plan as described in Title XIX of the Social Security Act</u> 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; or the individual is enrolled under an employee welfare benefit plan that is primary to medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan;

(b)

(i) 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 sixty-five 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 under this part has been terminated; or

(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.

(c)

(i) The individual is enrolled with:

(a) An eligible organization under a contract under section 1876 of the "Social Security Act" (medicare cost);

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

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

(d) An organization under a medicare select policy; and

(ii) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (O)(2)(b) of this rule.

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

(i)

(a) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

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

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

(iii) 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;

(e)

(i) 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 risk or cost), any similar organization operating under demonstration project authority, any "PACE" program under section 1894 of the "Social Security Act", or a medicare select policy; and

(ii) The subsequent enrollment under paragraph (O)(2)(e)(i) of this rule is terminated by the enrollee during any period within the first twelve months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the "Social Security Act"); or

(f) The individual, upon first becoming eligible for medicare "Part A" for benefits at age sixty-five or older, 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 months after the effective date of enrollment.

(g) 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 paragraph (O)(5)(d) of this rule.

(3) Guaranteed issue time periods

(a) In the case of an individual described in paragraph (O)(2)(a) of this rule, 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 days thereafter;

(b) In the case of an individual described in paragraph (O)(2)(b), (O)(2)(c), (O)(2)(e), or (O)(2)(f) of this rule whose enrollment terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three days after the date the applicable coverage is terminated;

(c) In the case of an individual described in paragraph (O)(2)(d)(i) of this rule, 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 days after the date the coverage is terminated;

(d) In the case of an individual described in paragraph (O)(2)(b), (O)(2)(d)(ii), (O)(2)(d)(iii), (O)(2)(e), or (O)(2)(f) of this rule, who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty days before the effective date of the disenrollment and ends on the date that is sixty-three days after the effective date;

(e) In the case of an individual described in paragraph (O)(2)(g) of this rule, 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 days after the effective date of the individual's coverage under medicare "Part D"; and

(f) In the case of an individual described in paragraph (O)(2) of this rule but not described in the preceding provisions of this paragraph, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three days after the effective date.

(4) Extended medigap access for interrupted trial periods

(a) In the case of an individual described in paragraph (O)(2)(e) of this rule (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in paragraph (O)(2)(e)(i) of this rule is involuntarily terminated within the first twelve 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 paragraph (O)(2)(e) of this rule;

(b) In the case of an individual described in paragraph (O)(2)(f) of this rule, (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in paragraph (O)(2)(f) of this rule is involuntarily terminated within the first twelve 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 paragraph (O)(2)(f) of this rule; and

(c) For the purposes of paragraphs (O)(2)(e) and (O)(2)(f) of this rule, no enrollment of an individual with an organization or provider described in paragraph (O)(2)(e)(i) of this rule, or with a plan or in a program described in paragraph (O)(2)(f) of this rule, 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.

(5) Products to which eligible persons are entitled

The medicare supplement policy to which eligible persons are entitled under:

(a) Paragraphs (O)(2)(a), (O)(2)(b), (O)(2)(c), and (O)(2)(d) of this rule 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.

(b)

(i) Subject to paragraph (O)(5)(b)(ii) of this rule, paragraph (O)(2)(e) of this rule 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 (O)(5)(a) of this rule;

(ii) 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 paragraph is:

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

(b) 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;

(c) Paragraph (O)(2)(f) of this rule shall include any medicare supplement policy offered by any issuer;

(d) Paragraph (O)(2)(g) of this rule 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.

(6) Notification provisions

(a) At the time of an event described in paragraph (O)(2) of this rule 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 paragraph (O) of this rule, and of the obligations of issuers of medicare supplement policies under paragraph (O)(1) of this rule. Such notice shall be communicated contemporaneously with the notification of termination.

(b) At the time of an event described in paragraph (O)(2) of this rule 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 paragraph (O) of this rule, and of the obligations of issuers of medicare supplement policies under paragraph (O)(1) of this rule. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

(P) Standards for claims payment

(1) 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 '87), Pub. L. No. 100-203) by:

(a) 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;

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

(c) Paying the participating physician or supplier directly;

(d) 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;

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

(f) 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.

(2) Compliance with the requirements set forth in paragraph (P)(1) of this rule shall be certified on the medicare supplement insurance experience reporting form.

(Q) Loss ratio standards and refund or credit of premium

(1) Loss ratio standards

(a)

(i) 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:

(a) At least seventy-five per cent of the aggregate amount of premiums earned in the case of group policies; or

(b) At least sixty-five per cent of the aggregate amount of premiums earned in the case of individual policies;

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

(a) Home office and overhead costs;

(b) Advertising costs;

(c) Commissions and other acquisition costs;

(d) Taxes;

(e) Capital costs;

(f) Administrative costs; and

(g) Claims processing costs.

(b) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of paragraph (Q) of this rule 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.

(c) For policies issued prior to May 1, 1992, expected claims in relation to premiums shall meet:

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

(ii) The appropriate loss ratio requirement from paragraphs (Q)(1)(a)(i)(a) and (Q)(1)(a)(i)(b) of this rule when combined with actual experience beginning January 1, 1996 to date; and

(iii) The appropriate loss ratio requirement from paragraphs (Q)(1)(a)(i)(a) and (Q)(1)(a)(i)(b) of this rule over the entire future period for which the rates are computed to provide coverage.

(d) In meeting the tests in paragraphs (Q)(1)(c)(i), (Q)(1)(c)(ii), and (Q)(1)(c)(iii) of this rule and for purposes of attaining credibility, an issuer may combine experience under policy forms which provide substantially similar coverage. Once a combined form is adopted, the issuer may not separate the experience except with the approval of the superintendent.

(2) Refund or credit calculation

(a) An issuer shall collect and file with the superintendent by May thirty-first of each year the data contained in the applicable reporting form contained in appendix A to this rule for each type in a standard medicare supplement benefit plan.

(b) If on the basis of the experience as reported, the benchmark ratio since inception (ratio one) exceeds the adjusted experience ratio since inception (ratio three), 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.

(c) For the purposes of this paragraph, policies or certificates issued prior to May 1, 1992, 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 effective date of this amendment. The first such report shall be due by May 31, 1998.

(d) 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 thirtieth following the experience year upon which the refund or credit is based.

(3) Annual filing of premium rates

(a) An issuer of medicare supplement policies and certificates issued before or after the effective date of this rule 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 superintendent in accordance with the filing requirements and procedures prescribed by the superintendent. 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. Such 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 years.

(b) 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 superintendent in accordance with the applicable filing procedures of this state:

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

(ii) 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 adjustments which would modify the loss ratio experience under the policy other than the adjustments described herein should be made with respect to a policy at any time other than upon its renewal date or anniversary date.

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

(c) 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.

(4) Public hearings

The superintendent 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 this rule 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 such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the superintendent.

(R) Filing and approval of policies and certificates and premium rates

(1) 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 superintendent in accordance with filing requirements and procedures prescribed by the superintendent.

(2) 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 superintendent in the state in which the policy or certificate was issued.

(3) 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 superintendent in accordance with the filing requirements and procedures prescribed by the superintendent. The superintendent shall use the following process for approving or disapproving proposed premium increases:

(a) As used in paragraph (R)(3) of this rule, "benefits provided are not unreasonable in relation to the premium charged" means that the rates were calculated in accordance with sound actuarial principles.

(b) With respect to any filing of any premium rates for any individual or group medicare supplement policy, or for any endorsement or rider pertaining thereto, the superintendent of insurance may, within thirty days after filing:

(i) Disapprove such filing if the superintendent finds that the benefits provided are unreasonable in relation to the premium charged. Such disapproval shall be effected by written order of the superintendent, a copy of which shall be mailed to the issuer that has made the

filing. In the order, the superintendent shall specify the reasons for disapproval and state that a hearing will be held within fifteen days after requested in writing by the issuer. If a hearing is so requested, the superintendent shall also give such public notice, if appropriate. The superintendent, within fifteen days after the commencement of any hearing, shall issue a written order, a copy of which shall be mailed to the issuer that has made the filing, either affirming the prior disapproval or approving such filing if it is determined that the benefits provided are not unreasonable in relation to the premium charged; or

(ii) Set a date for a public hearing to commence no later than forty days after the filing. The superintendent shall give the issuer making the filing twenty days' written notice of the hearing and shall give such public notice as appropriate. The superintendent, within twenty days after the commencement of a hearing, shall issue a written order, a copy of which shall be mailed to the issuer that has made the filing, either approving such filing if it is determined that the benefits provided are not unreasonable in relation to the premium charged, or disapproving such filing if it is determined that the benefits provided are unreasonable in relation to the premium charged; or

(iii) Take no action, in which case such filing shall be deemed to be approved and shall become effective upon the thirty-first day after such filing, unless the superintendent has previously given written approval to the issuer.

(c) At any time any filing has been approved pursuant to this section, the superintendent may, after a hearing of which at least twenty days' written notice has been given to the issuer that has made such filing and for which such public notice as is appropriate has been given, withdraw approval of such filing if it is determined that the benefits provided are unreasonable in relation to the premium charged. Such withdrawal of approval shall be effected by written order of the superintendent, a copy of which shall be mailed to the issuer that has made the filing, which shall state the ground for such withdrawal and the date, not less than forty days after the date of such order, when the withdrawal or approval shall become effective.

(d) The superintendent may retain at the issuer's expense such attorneys, actuaries, accountants, and other experts not otherwise a part of the superintendent's staff as shall be reasonably necessary to assist in the preparation for and conduct of any public hearing under this section. The

expense for retaining such experts and the expenses of the department of insurance incurred in connection with such public hearing shall be assessed against the issuer in an amount not to exceed one one-hundredth of one per cent of the sum of premiums earned plus net realized investments gain or loss of such issuer as reflected in the most current annual statement on file with the superintendent. Any person retained shall be under the direction and control of the superintendent and shall act in a purely advisory capacity.

(4)

(a) Except as provided in paragraph (R)(4)(b) of this rule, 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.

(b) An issuer may offer, with the approval of the superintendent, up to four 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:

(i) The inclusion of new or innovative benefits;

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

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

(iv) The offering of coverage to individuals eligible for medicare by reason of disability.

(c) For the purposes of this paragraph, a "type" means an individual policy, a group policy, an individual medicare select policy, or a group medicare select policy.

(5)

(a) Except as provided in paragraph (R)(5)(a)(i) of this rule, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this rule that has been approved by the superintendent. 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 months.

(i) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the superintendent in

writing its decision at least thirty days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the superintendent, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(ii) An issuer that discontinues the availability of a policy form or certificate form pursuant to paragraph (R)(5)(a)(i) of this rule 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 years after the issuer provides notice to the superintendent of the discontinuance. The period of discontinuance may be reduced if the superintendent determines that a shorter period is appropriate.

(b) The sale or other transfer of medicare supplement business to another issuer shall be considered a discontinuance for the purposes of paragraph (R)(5) of this rule.

(c) A change in the rating structure or methodology shall be considered a discontinuance under paragraph (R)(5)(a) of this rule unless the issuer complies with the following requirements:

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

(ii) 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 superintendent may approve a change to the differential which is in the public interest.

(6)

(a) Except as provided in paragraph (R)(6)(b) of this rule, 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 paragraph (Q) of this rule.

(b) 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.

(S) Permitted compensation arrangements

(1) 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 two hundred per cent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(2) 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 renewal years. After the fifth renewal year, any commission or other compensation provided may be up to that provided in the previous renewal year.

(3) 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.

(4) For purposes of paragraphs (N) and (S) of this rule, "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.

(5) No issuer or other entity shall violate the provisions of paragraph (N)(4) of this rule.

(T) Required disclosure provisions

(1) General rules.

(a) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision shall be consistent with the type of contract issued. 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 age of the policyholder or certificate holder.

(b) 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, 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 other than the right to reduce or eliminate benefits or coverage, or is required to reduce or eliminate benefits to avoid duplication of medicare benefits. 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.

(c) 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.

(d) 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."

(e) 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 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.

(f)

(i) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person(s) 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 the "Centers for Medicare and Medicaid Services" ("CMS") and in a type size no smaller than twelve point type. Delivery of the guide shall be made whether or not such policies or certificates are advertised, solicited or issued as medicare supplement policies or certificates as defined in this rule. 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.

(ii) For the purposes of paragraph (T)(1)(f) of this rule, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(2) Notice requirements.

(a) As soon as practicable, but no later than thirty 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 policies or certificates in a format acceptable to the superintendent. The requirements of this paragraph apply to medicare supplement policies and certificates delivered or issued for delivery in this state before or after the effective date of this rule. The notice shall be in twelve point type in a format acceptable to the superintendent. The notice shall:

(i) 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

(ii) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in medicare.

(b) 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.

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

(3) "MMA" notice requirements.

Issuers shall comply with any notice requirements of the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003."

(4) Outline of coverage requirements for medicare supplement policies.

(a) 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

(b) 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~~ necessitate revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve-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."

(c) The outline of coverage provided to applicants pursuant to paragraph (T) of this rule shall be in the form prescribed in appendix C to this rule, and 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, format and order prescribed in appendix C to this rule in no less than twelve point type. All plans shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(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, layout, and format as shown in the charts in appendix C to this rule. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in appendix C to this rule. An issuer may use additional benefit plan designations on these charts pursuant to paragraphs (J)(4) and (K)(5) of this rule as applicable.)

(Include an explanation of any smoker/non-smoker rates or household discounts in the premium information and disclosure pages, in a manner approved by the superintendent.)

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

(5) Notice regarding policies or certificates which are not medicare supplement policies.

(a) Any sickness and accident insurance policy or certificate, other than a medicare supplement policy or a policy issued pursuant to a contract under section 1876 of the "Social Security Act" (42 U.S.C. section 1395, et seq.); disability income policy; or other policy identified in paragraph (C)(2) of this rule, 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-point type and shall contain the following language:

"This (policy or certificate) is not a medicare supplement (policy or certificate). If you are eligible for medicare, review the "Guide to Health Insurance for People with Medicare" available from the company."

(b) Applications provided to persons eligible for medicare for the health insurance policies or certificates described in paragraph (T)(4)(a) of this rule shall disclose, using the applicable statement in appendix F to this rule, 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.

(U) Requirements for application forms and replacement coverage

(1) Application forms shall include the statements and questions in appendix D to this rule 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 sickness and accident policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, containing such statements and questions may be used.

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

(3) 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 such 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.

(4) The notice required by paragraph (U)(3) of this rule, for an issuer shall be as provided in appendix E to this rule in substantially the same form and in no less than twelve point type.

(V) Filing requirements for advertising

(1) Each issuer of medicare supplement policies or certificates in this state shall provide to the superintendent, prior to its use, a copy of any medicare supplement advertisement intended for use in this state, whether through written or electronic media. No such advertisement shall be used unless approved in writing by the superintendent. Any advertisement not disapproved within thirty days after filing shall be deemed approved.

(2) If the image or voice of a celebrity is used in the advertisement, any medicare supplement advertisement shall disclose that the celebrity has been paid to endorse or advertise the policy.

In radio and television advertising, the disclosure shall be spoken by the celebrity. In print advertising, the disclosure shall appear in at least twelve-point type, surrounded by a black line box. There shall be at least one-eighth inch blank space between the black line box and the text of the disclosure. The box shall surround no other text or graphic image.

An issuer may determine the precise language in which it makes this disclosure, provided the language is clear and unambiguous.

(W) Standards for marketing

(1) An issuer, directly or through its producers, shall:

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

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

(c) 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."

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

(e) Establish auditable procedures for verifying compliance with paragraph (W) (1) of this rule.

(2) In addition to the practices prohibited in sections 3901.19 to 3901.221 of the Revised Code, paragraph (C) of rule 3901-1-07 of the Administrative Code, and paragraph (D) of rule 3901-8-09 of the Administrative Code, the following acts and practices are prohibited:

(a) 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 any insurance policy or to take out a policy of insurance with another insurer.

(b) 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.

(c) 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.

(3) 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 rule.

(X) Appropriateness of recommended purchase and excessive insurance

(1) 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.

(2) Any sale of a medicare supplement policy or certificate that will provide an individual more than one medicare supplement policy or certificate is prohibited.

(3) 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.

(Y) Reporting of multiple policies

(1) On or before March first 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:

(a) Policy and certificate number, and

(b) Date of issuance.

(2) The items set forth above must be grouped by individual policyholder.

(3) Attached as appendix B to this rule is a reporting form for compliance with paragraph (Y) of this rule.

(Z) Prohibition against preexisting conditions, waiting periods, elimination periods and probationary periods in replacement policies or certificates.

(1) 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 to the extent such time was spent under the original policy.

(2) If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

(AA) Prohibition against use of genetic information and requests for genetic testing for policy years beginning on or after May 21, 2009.

(1) An issuer of a medicare supplement policy or certificate 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 preexisting condition) and 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.

(2) Nothing in paragraph (AA)(1) of this rule shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

(a) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for an employer based on the manifestation of a disease or disorder of an insured or applicant; or

(b) 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.)

(3) An issuer of a medicare supplement policy or certificate shall not request or ~~require~~ obligate an individual or a family member of such individual to undergo a genetic test.

(4) Paragraph (AA)(3) of this rule ~~shall~~ does 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 paragraph (AA)(1) of this rule.

(5) For purposes of carrying out paragraph (AA)(4) of this rule, an issuer of a medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

(6) Notwithstanding paragraph (AA)(3) of this rule, an issuer of a medicare supplement policy may request, but not require, that an individual or a family member of such an individual undergo a genetic test if each of the following conditions is met:

(a) The request is made pursuant to research that complies with section 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.

(b) 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:

(i) Compliance with the test is voluntary; and

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

(c) No genetic information collected or acquired under paragraph (AA)(6) of this rule 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.

(d) The issuer notifies the secretary in writing that the issuer is conducting activities pursuant to the exception provided for under paragraph (AA)(6) of this rule, including a description of the activities conducted.

(e) The issuer complies with such other conditions as the secretary may by regulation require for activities conducted under paragraph (AA)(6) of this rule.

(7) An issuer of a medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

(8) 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.

(9) 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 paragraph (AA)(8) of this rule if such request, requirement, or purchase is not in violation of paragraph (AA)(7) of this rule.

(10) For the purposes of paragraph (AA) of this rule:

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

(b) "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.

(c) "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.

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

(e) "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.

(f) "Underwriting purposes" means:

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

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

(iii) The application of any preexisting condition exclusion under the policy;

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

(BB) Severability

If any paragraph, term or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other paragraph, term or provision of this rule, but the remaining paragraphs, terms or provisions shall be and continue in full force and effect.

Effective: 5/1/2023

Five Year Review (FYR) Dates: 2/14/2023 and 08/31/2027

CERTIFIED ELECTRONICALLY

Certification

04/21/2023

Date

Promulgated Under: 119.03
Statutory Authority: 3901.041, 3923.33, 3923.331 to 3923.339
Rule Amplifies: 3923.33, 3923.331 to 3923.339
Prior Effective Dates: 06/04/1982, 02/10/1989 (Emer.), 07/24/1989 (Emer.), 11/10/1989, 12/28/1989 (Emer.), 10/19/1990, 05/01/1992, 04/26/1996, 11/19/1998 (Emer.), 01/14/1999, 08/01/2001, 11/14/2002, 08/04/2005, 07/01/2009, 03/27/2014, 11/15/2018

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.

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 and/or credit against premiums to be used must be attached to this form.

[1]Individual, group, individual Medicare Select, or group Medicare Select only
[2]"SMSBP" – Standardized Medicare Supplement Benefit Plan - Use "P" for prestandardized plans.
[3]Includes Model 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"

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] Year	(b)[4] Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(o)[5] 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 prestandardized plans
[3]Year 1 is the current 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] Year	(b)[4] Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(o)[5] 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 prestandardized plans
[3]Year 1 is the current 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

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

This chart shows the benefits included in each of the standard Medicare supplement plans with an effective date for coverage on or after June 1, 2010. Every company must make Plan "A" available. Some plans may not be available in your state.

Basic Benefits:

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

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance *		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance		Skilled Nursing Facility Co-insurance	50% Skilled Nursing Facility Co-insurance	75% Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% 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			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit $[ ]; paid at 100% after limit reached	Out-of-pocket limit $[ ]; 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 [$] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed [$]. 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.

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 & 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 rule. An issuer may use additional benefit plan designations on these charts pursuant to paragraph (K)(4) of this rule.]

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

[Include an explanation of any smoker/non-smoker rates or household discounts in the premium information and disclosure pages, in a manner approved by the superintendent.]

* * * *

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 $[ ]	$0	$[ ] (Part A deductible)
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	$0	Up to $[ ] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN A

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

* Once you have been billed $[ ] 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 $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	$0	Up to $[ ] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN B

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

* Once you have been billed $[ ] 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 $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN C

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

* Once you have been billed $[ ] 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 $[ ] of Medicare Approved Amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare Approved Amounts*	$0	$[ ] (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

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN 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 $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN D

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

* Once you have been billed $[ ] 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 $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN D (continued)

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN 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 [$] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$]. 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 [$] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO [$] DEDUCTIBLE, **] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0***
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN F OR HIGH DEDUCTIBLE PLAN F

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

* Once you have been billed $[ ] 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 [$] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$]. 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 [$] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO [$] 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 $[ ] of Medicare Approved Amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare Approved Amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F OR HIGH DEDUCTIBLE PLAN F (continued)

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN 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 $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN G

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

* Once you have been billed $[ ] 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 $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (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 $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G (continued)

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[ ] 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 $[ ]	$[ ] (50% of Part A deductible)	$[ ] (50% of Part A deductible) ♦
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0***
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	Up to $[ ] a day (50% of Part A Coinsurance)	Up to $[ ] a day (50% of Part A Coinsurance) ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50% ♦
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance ♦

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

PLAN K

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

**** Once you have been billed $[ ] 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 $[ ] of Medicare Approved Amounts****	$0	$0	$[ ] (Part B deductible) *** ♦
Preventive Benefits for Medicare Covered Services	Generally 80% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $[ ])*
BLOOD			
First 3 pints	$0	50%	50% ♦
Next $[ ] of Medicare Approved Amounts****	$0	$0	$[ ] (Part B deductible) **** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[ ] 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 (continued)

PARTS A&B

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

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

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[ ] 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 $[ ]	$[ ] (75% of Part A deductible)	$[ ] (25% of Part A deductible) ♦
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0***
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	Up to $[ ] a day (75% of Part A Coinsurance)	Up to $[ ] a day (25% of Part A Coinsurance) ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25% ♦
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance	25% of copayment/coinsurance ♦

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

PLAN L

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

**** Once you have been billed $[ ] 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 $[ ] of Medicare Approved Amounts****	$0	$0	$[ ] (Part B deductible) **** ♦
Preventive Benefits for Medicare Covered Services	Generally ~~75%~~ 80% 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 $[ ])*
BLOOD			
First 3 pints	$0	75%	25% ♦
Next $[ ] of Medicare Approved Amounts****	$0	$0	$[ ] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[ ] 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 (continued)

PARTS A&B

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

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

PLAN M

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

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any 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 $[ ]	$[ ] (50% of Part A deductible)	$[ ] (50% of Part A deductible)
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN M

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

* Once you have been billed $[ ] 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 $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN 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 $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN N

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

* Once you have been billed $[ ] 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 $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to [$] per office visit and up to [$] per emergency room visit. The copayment of up to [$] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [$] per office visit and up to [$] per emergency room visit. The copayment of up to [$] 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 $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N (continued)

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

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

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

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

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G*	K	L	M	N	C	F*
Medicare Part A coinsurance and hospice coverage (up to an additional 365 days after medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply***	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in [2018]					[$5240]**	[$2620]**				

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

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

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

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.

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 & 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 rule. An issuer may use additional benefit plan designations on these charts pursuant to paragraph (K)(4) of this rule.]

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

[Include an explanation of any smoker/non-smoker rates or household discounts in the premium information and disclosure pages, in a manner approved by the superintendent.]

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 $[ ]	$0	$[ ] (Part A deductible)
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	$0	Up to $[ ] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN A

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

* Once you have been billed $[ ] 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 $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	$0	Up to $[ ] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN B

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

* Once you have been billed $[ ] 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 $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN C

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

* Once you have been billed $[ ] 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 $[ ] of Medicare Approved Amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare Approved Amounts*	$0	$[ ] (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

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN 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 $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN D

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

* Once you have been billed $[ ] 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 $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN D (continued)

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN 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 [$] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$]. 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 [$] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO [$] DEDUCTIBLE, **] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0***
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN F OR HIGH DEDUCTIBLE PLAN F

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

* Once you have been billed $[ ] 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 [$] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$]. 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 [$] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO [$] 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 $[ ] of Medicare Approved Amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$100	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare Approved Amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F OR HIGH DEDUCTIBLE PLAN F (continued)

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN G OR HIGH DEDUCTIBLE PLAN G

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

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

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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE, **] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0***
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN G or HIGH DEDUCTIBLE PLAN G

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

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

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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE, **] YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Unless Part B deductible has been met)
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 $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G or HIGH DEDUCTIBLE PLAN G

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[ ] 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 $[ ]	$[ ] (50% of Part A deductible)	$[ ] (50% of Part A deductible) ♦
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0***
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	Up to $[ ] a day (50% of Part A Coinsurance)	Up to $[ ] a day (50% of Part A Coinsurance) ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50% ♦
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance ♦

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

PLAN K

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

**** Once you have been billed $[ ] 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 $[ ] of Medicare Approved Amounts****	$0	$0	$[ ] (Part B deductible) *** ♦
Preventive Benefits for Medicare Covered Services	Generally 80% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $[ ])*
BLOOD			
First 3 pints	$0	50%	50% ♦
Next $[ ] of Medicare Approved Amounts****	$0	$0	$[ ] (Part B deductible) **** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[ ] 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 (continued)

PARTS A&B

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

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

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[ ] 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 $[ ]	$[ ] (75% of Part A deductible)	$[ ] (25% of Part A deductible) ♦
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0***
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	Up to $[ ] a day (75% of Part A Coinsurance)	Up to $[ ] a day (25% of Part A Coinsurance) ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25% ♦
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance	25% of copayment/coinsurance ♦

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

PLAN L

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

**** Once you have been billed $[ ] 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 $[ ] of Medicare Approved Amounts****	$0	$0	$[ ] (Part B deductible) **** ♦
Preventive Benefits for Medicare Covered Services	Generally 80% 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 $[ ])*
BLOOD			
First 3 pints	$0	75%	25% ♦
Next $[ ] of Medicare Approved Amounts****	$0	$0	$[ ] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[ ] 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 (continued)

PARTS A&B

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

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

PLAN M

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

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any 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 $[ ]	$[ ] (50% of Part A deductible)	$[ ] (50% of Part A deductible)
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN M

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

* Once you have been billed $[ ] 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 $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN 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 $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ] a day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN N

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

* Once you have been billed $[ ] 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 $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to [$] per office visit and up to [$] per emergency room visit. The copayment of up to [$] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [$] per office visit and up to [$] per emergency room visit. The copayment of up to [$] 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 $[ ] of Medicare Approved Amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N (continued)

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

APPENDIX D

[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 twenty-four (24) months. You must request this suspension within ninety (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 ninety (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 with this 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 policy, leave "END" blank.)

(6) Agent shall list any other health insurance policies agent has sold to the applicant.

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

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

APPENDIX E

NOTICE TO APPLICANT REGARDING REPLACEMENT 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. [Boldface type]

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 OR AGENT [BROKER OR OTHER REPRESENTATIVE] [Boldface type]:

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 which 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

APPENDIX F

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 pre-empt state laws that are more stringent than the federal requirements.
8. The federal law does not pre-empt 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 F 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 senior health insurance assistance program ("SHIP").

[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 senior health insurance assistance program ("SHIP").

[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 senior health insurance assistance program ("SHIP").

[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 senior health insurance assistance program ("SHIP").

[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 senior health insurance assistance program ("SHIP").

[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 both expenses 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 senior health insurance assistance program ("SHIP").

[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 previous 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.

√ For help in understanding your health insurance, contact your state insurance department or state senior health insurance assistance program ("SHIP").

[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.]

[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 G*uide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior health insurance assistance program ("SHIP").

[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.]

[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.

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

√ For help in understanding your health insurance, contact your state insurance department or state senior health insurance assistance program ("SHIP").

[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.]

[Alternative 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 IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

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 G*uide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior health insurance assistance program ("SHIP").

[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.]

[Alternative 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 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 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.

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 G*uide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior health insurance assistance program ("SHIP").

[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.]

[Alternative 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 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 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.

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 G*uide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior health insurance assistance program ("SHIP").

[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.]

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis]

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 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.

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

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 G*uide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior health insurance assistance program ("SHIP").

[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.]

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements]

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 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 G*uide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior health insurance assistance program ("SHIP").

[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.]

Ohio | Common Sense Initiative

Mike DeWine, Governor | **Jon Husted**, Lt. Governor | **Joseph Baker**, Director

Business Impact Analysis

Agency Name: ***Ohio Department of Insurance***
Rule Contact Name: ***Loretta Medved***
Rule Contact Information: ***loretta.medved@insuance.ohio.gov***
614-644-0239

Regulation/Package Title *(a general description of the rules' substantive content)*:
Medicare Supplement

Rule Number(s): ***3901-8-08 Medicare supplement***

Date of Submission for CSI Review: ***December 27, 2022***
Public Comment Period End Date: ***January 21, 2023 12:00am***

Rule Type/Number of Rules:

- ☐ New/ rules
- ☒ Amended/ ***1*** rules (FYR?)
- ☐ No Change/ rules (FYR?)
- ☐ Rescinded/ rules (FYR?)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. R.C. 106.03 and 106.031 requires agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.

   Which adverse impact(s) to businesses has the Agency determined the rule(s) create?

   The rule(s):

   - ☒ a. Requires a license, permit, or any other prior authorization to engage in or operate a line of business.
   - ☐ b. Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.
   - ☒ c. Requires specific expenditures or the report of information as a condition of compliance.
   - ☐ d. Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.

Regulatory Intent

2. Please briefly describe the draft regulation in plain language.
   Please include the key provisions of the regulation as well as any proposed amendments.

   The purpose of this rule is to provide for the standardization of coverage of Medicare Supplement policies. A Medicare Supplement (Med Supp) policy helps pay some of the health care costs that original Medicare doesn't cover such as co-payments, coinsurance and deductibles. Medicare Supplement policies are standardized according to federal law. Each state then implements the federal standards. Following passage of the applicable federal law, the National Association of Insurance Commissioners (NAIC) works with various states and interested parties to update the "Medicare Supplement NAIC model law." States then adopt the NAIC model law to maintain compliance with the federal requirements and uniformity among the states. This rule, 3901-8-08 Medicare Supplement, is based on the most current NAIC model.

   The proposed substantive amendment found in paragraph (O)(2)(a) will expand the definition of eligible persons to include individuals who have lost state Medicaid benefits as a result of plan termination and will establish a guarantee issue opportunity for individuals that lose Medicaid benefits when the federal public health emergency ends.

   Additional techinical amedments will reduce regulatory restrictions in accordance with the requirements of ORC 121.951 (SB 9).

3. Please list the Ohio statute(s) that authorize the Agency to adopt the rule(s) and the statute(s) that amplify that authority.

Sections 3901.041, 3923.33, and 3923.331 to 3923.339 of the Revised Code.

4. Does the regulation implement a federal requirement? ☒ Yes ☐ No
   Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?
   ☐ Yes ☒ No
   If yes, please briefly explain the source and substance of the federal requirement.

   The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a major piece of federal legislation affecting many aspects relating to healthcare payments, including a redesign of some Med Supp policies.

5. If the regulation implements a federal requirement, but includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

   This rule is based on the NAIC model which provides the framework for states to implement federal requirements for Med Supp policies. The model overlays the state framework with the federal requirements, but allows for some state specific decisions to be made.

6. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

   This rule works to facilitate consumer understanding and comparison of Med Supp policies and to provide for disclosures in the sale of such policies. This type of policy provides a valuable option to Medicare enrollees. Costs not covered by Medicare can add up quickly and can be especially difficult for people that are traditionally on a fixed income. The purpose of this rule is to ensure these plans are standardized for ease of consumer understanding and that the plans are compliant with federal law. The proposed amendment will further consumer protection by providing individuals who lose coverage under Medicaid the option to purchase a Med Supp plan, which otherwise is not available outside of open enrollment periods.

7. How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?

   The measure of success will be a better understanding among Medicare enrollees of what Med Supp plans offer, resulting in fewer questions regarding the terms and benefits of their supplement policy. The department will also measure the success by fewer complaints and administrative actions against Medicare supplement insurers.

8. Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931? ☐ Yes ☒ No

   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

Not applicable.

Development of the Regulation

9. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation. *If applicable, please include the date and medium by which the stakeholders were initially contacted.*

   On November 18, 2022, the department sent an email requesting comment to industry stakeholders, including companies offering Med Supp plans, consumer groups, and associations such as the Ohio Association of Health Plans, the Ohio Insurance Agents Association, the National Association of Insurance and Financial Advisors, and the Ohio Insurance Underwriters Association. A follow-up email was also sent on December 1, 2022.

   The Department submitted the rule to CSI for review on December 27, 2022. One comment of support was received during the two week comment period. Upon conclusion of the comment period, the Department proposed additional technical amendments to reduce regulatory restrictions in accordance with the requirements of ORC 121.951 (SB 9). The Department will resubmit the rule to CSI on January 13, 2023 and open a one week comment period.

10. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

    No comments were received.

11. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

    The NAIC works with various state insurance departments and industry stakeholders to update the "Medicare Supplement NAIC model law." States then adopt the NAIC model law to maintain compliance with the federal requirements and uniformity among the states. The proposed amendment was drafted to provide an option for individuals whom will face a loss of coverage when the public health emergency ends, as well as any termination of Medicaid benefits.

12. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives? *Alternative regulations may include performance based regulations, which define the required outcome, but do not dictate the process the regulated stakeholders must use to comply.*

    Med Supp plans are standardized nationally and then adopted into state regulations. This method is preferred by the regulated community, the NAIC, and the department to promote

uniformity and compliance with federal guidance across the states. Due to the requirements of standardization, an alternative regulation is not appropriate.

13. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

    The department maintains sole regulatory authority over health insurers; no other regulation duplicates this rule.

14. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

    Department staff will be available to review new product filings or any other administrative filings using the rule's specific requirements. The use of the NAIC model within the rule assists with consistency to prior versions of this rule, as well as predictability throughout the regulated community.

Adverse Impact to Business

15. Provide a summary of the estimated cost of compliance with the rule(s). Specifically, please do the following:
    a. Identify the scope of the impacted business community; and
    b. Quantify and identify the nature of the adverse impact (e.g., fees, fines, employer time for compliance).
       The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a representative business. Please include the source for your information/estimated impact.

    a. This rule applies to all health plan issuers engaging in the sale of Med Supp policies in the state of Ohio.

    b. This rule impacts internal company resources which may include IT systems, publication edits, time to prepare new filings and staff training time. The proposed amendment will require a review and revision to existing practices. In order to remain in compliance with this rule, health insurance companies should monitor staff communications and training, as well as their internal IT systems and procedures.

16. Are there any proposed changes to the rule(s) that will reduce a regulatory burden imposed on the business community? Please identify. *(Reductions in regulatory burden may include streamlining reporting processes, simplifying rules to improve readability, eliminating requirements, reducing compliance time or fees, or other related factors.)*

    There are no proposed changes to the rule that will reduce regulatory burden.

17. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

This rule applies only to health insurance companies selling Med Supp policies and is intended to establish standards that will promote consistency and accountability in the sale of such policies. Although the amendment will impose a change to current business practices, the option to purchase a med supp plan for individuals who have lost coverage due to plan termination with Medicaid, this establishes a consumer protection and outweighs the potential adverse impact on insurance companies.

Regulatory Flexibility

18. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

The requirements of this rule are intended to promote a standardized environment for the sale of Med Supp policies as required by federal law. Therefore, it is essential that all health insurance companies engaging in the sale of these policies, regardless of size, comply consistently with the requirements of this rule.

19. How will the Agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

Non-compliant filings are identified in the review process and discussed with the company. Generally, companies agree to change a filing as requested by the department, propose an alternative solution, or will withdraw the filing. Paperwork violations and/or first time offender issues would be dealt with on a case-by-case basis due to the fact that these types of violations could impact the consumer. There is no fine or penalty for paperwork violations under this rule.

20. What resources are available to assist small businesses with compliance of the regulation?

Should an entity have any questions about achieving compliance with this rule, department staff will be available to answer any questions.

Ohio | Common Sense Initiative

Mike DeWine, Governor
Jon Husted, Lt. Governor

Joseph Baker, Director

MEMORANDUM

TO: Loretta Medved, Ohio Department of Insurance

FROM: Michael Bender, Business Advocate

DATE: February 8, 2023

RE: **CSI Review – Medicare Supplement (OAC 3901-8-08)**

On behalf of Lt. Governor Jon Husted, and pursuant to the authority granted to the Common Sense Initiative (CSI) Office under Ohio Revised Code (ORC) section 107.54, the CSI Office has reviewed the abovementioned administrative rule package and associated Business Impact Analysis (BIA). This memo represents the CSI Office's comments to the Department as provided for in ORC 107.54.

Analysis

This rule package consists of one amended rule proposed by the Ohio Department of Insurance (ODI). This rule package was submitted to the CSI Office on December 27, 2022, and the public comment period was held open through January 11, 2023. A supplemental comment period was held from January 13, 2023, through January 20, 2023. Unless otherwise noted below, this recommendation reflects the version of the proposed rule filed with the CSI Office on January 13, 2023.

Ohio Administrative Code (OAC) 3901-8-08 provides for the standardization of Medicare Supplement policies. The rule is amended to update language and to expand eligibility for a guaranteed issue opportunity to include individuals who due to plan termination or cessation of benefits have lost state Medicaid benefits that supplement Medicare benefits, with the goal of making this option available for individuals who will lose coverage when the federal COVID-19 public health emergency ends. According to ODI, the National Association of Insurance Commissioners (NAIC) works with various states and interested parties to update its Medicare Supplement model law that complies with federal requirements as they change. This rule is based on the most current NAIC model.

During early stakeholder outreach, ODI sent an email on November 18, 2022, requesting comments on the proposed rule to industry stakeholders, which included companies offering Medicare Supplement plans, consumer groups, the Ohio Association of Health Plans, the Ohio Insurance Agents Association, the National Association of Insurance and Financial Advisors, and the Ohio Insurance Underwriters Association. ODI sent a follow up email on December 1, 2022. No comments were received in response to either email request. During the initial CSI public comment period, ODI received one comment from an individual in support of the rule. ODI subsequently made technical revisions to the rule. No comments were received during the supplemental comment period.

The business community impacted by the rule includes all health plan issuers that engage in the sale of Medicare Supplement policies in Ohio. The adverse impacts created by the rule include limitations on what can be offered in Medicare Supplement policies, maintaining proper IT systems and publications, and the time necessary to prepare filings and train staff. ODI states that the adverse impacts to business are justified to implement federal standards, promote consistency and accountability in the sale of Medicare Supplement policies, facilitate consumer understanding and comparison of Medicare Supplement policies, and provide the option to purchase a Medicare Supplement plan for individuals who have lost Medicaid coverage due to termination.

Recommendations

Based on the information above, the CSI Office has no recommendations on this rule package.

Conclusion

The CSI Office concludes that ODI should proceed in filing the proposed rule with the Joint Committee on Agency Rule Review.

Ohio Department of Insurance

Mike DeWine, Governor
Jon Husted, Lt. Governor

Judith L. French, Director

50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215-4186
(614) 644-2658

MEMORANDUM

To: Michael Bender, Business Advocate, Common Sense Initiative Office

CC: Joseph Baker, Director of the Common Sense Initiative Office

From: Loretta Medved, Policy Analyst

Date: February 10th, 2023

Re: Response to CSI Review – Medicare Supplement (OAC 3901-8-08)

On February 8, 2023, the Ohio Department of Insurance (the Department) received the Recommendation Memorandum (CSI Recommendation) from the Common Sense Initiative Office for rule 3901-8-08 Medicare Supplement.

The CSI Recommendation stated that the office does not have any recommendations regarding this rule package, and therefore should proceed with a formal filing of the rule package.

At this time, the Department plans to move forward with the filing of this rule package with the Joint Committee on Agency Rule Review.

If you have any questions please contact Loretta Medved at 614-644-0239 or Loretta.Medved@insurance.ohio.gov.