

in significant changes in the used device's safety or performance specifications, or intended use. Public comment and input were solicited concerning alternative regulatory approaches the agency might consider in applying regulatory controls upon the activities of "refurbishers," "as-is remarketers," and "servicers," or other types of used-device processors identified following comments. As a consequence of these agency actions, the guidance in CPG 7124.28 concerning the applicability of registration, listing, and other statutory and regulatory requirements to "reconditioners/rebuilders" of used devices is obsolete and no longer represents current agency thinking. Pending FDA's issuance of a rule or guidance setting forth the agency's current position on these matters, FDA is revoking, rather than revising CPG 7124.28 in its entirety in order to eliminate obsolete guidance, minimize confusion, and reduce attendant industry burdens.

Dated: October 23, 1998.

D.B. Burlington,

Director, Center for Devices and Radiological Health.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA-2025-N]

RIN 0938-AJ07

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

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

ACTION: Notice.

SUMMARY: This notice describes changes made by the Balanced Budget Act of 1997 to section 1882 of the Social Security Act, which governs Medicare supplemental insurance. It also recognizes that the Model Regulation adopted by the National Association of Insurance Commissioners (NAIC) on April 29, 1998, as corrected and clarified by HCFA, is considered to be the applicable NAIC Model Regulation for purposes of section 1882 of the Social Security Act. The changes made by HCFA (1) correct a drafting error in section 12.B(2) of the Model that is inconsistent with Federal law, and (2) add a clarification that copayments for hospital outpatient department services under Part B of Medicare must be

covered under the "core benefits" of a Medicare supplemental insurance policy in the same manner as coinsurance for those services. Finally, this notice prints as an addendum the full text of the NAIC Model Regulation, as corrected and clarified by HCFA.

DATES: Medicare supplemental insurance policies issued in any State must conform to the requirements of section 1882(s)(3) of the Social Security Act as of July 1, 1998, and to the standards contained in the revised NAIC Model Regulation as of the date the State adopts the revised standards, which generally must be no later than April 29, 1999.

FOR FURTHER INFORMATION CONTACT: Terese Klitenic (410) 786-1565.

SUPPLEMENTARY INFORMATION:

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I. Background

A. The Medicare Program

The Medicare program was established by Congress in 1965 with the enactment of title XVIII of the Social Security Act (the Act). The program provides payment for certain medical

services for persons 65 years of age or older, disabled beneficiaries, and persons with end-stage renal disease. The Medicare program consists of two separate but complementary insurance programs, a hospital insurance program (Part A), which covers services furnished by hospitals, skilled nursing facilities, home health agencies and hospices; and a supplementary medical insurance program (Part B), which covers a wide range of medical services and supplies, including physicians' services, outpatient hospital services, outpatient physical and occupational therapy services, and home health services. Part B also covers certain drugs and biologicals that cannot be self-administered, diagnostic x-ray and laboratory tests, purchase or rental of durable medical equipment, ambulance services, prosthetic devices, and certain medical supplies.

While the Medicare program provides extensive hospital insurance benefits and supplementary medical insurance, it was not designed to cover the total cost of medical care for Medicare beneficiaries. Amounts payable under both Parts A and B are reduced by certain deductible and coinsurance amounts for which the beneficiary is responsible.

In 1998, the Part A inpatient hospital deductible is \$764 (\$768 for 1999) for each "benefit period" (the period beginning on the first day of hospitalization and extending until the beneficiary is no longer an inpatient of a hospital or skilled nursing facility for 60 consecutive days).

The Part B deductible is \$100 for calendar years 1998 and 1999. Beneficiaries are also responsible for paying certain coinsurance amounts for covered items and services. For example, the coinsurance applicable to physicians' services under Part B is generally 20 percent of the Medicare-approved amount for the service. When beneficiaries receive covered services from physicians who do not accept assignment of their Medicare claims, the beneficiaries may also be required to pay amounts in excess of the Medicare approved amount ("excess charges"), up to a limit established under the Act.

There are a number of items and services that are not covered under either Part A or Part B; for example, custodial nursing home care, most dental care, eyeglasses, and most prescription drugs are not covered. Beneficiaries must pay the full cost of these items and services out-of-pocket or may purchase additional private insurance to help pay the costs.

Because Medicare does not cover the total cost of providing medical care, a

substantial number of Medicare beneficiaries have some type of private health coverage. This coverage may include Medicare supplemental insurance, employer group health plans, hospital indemnity insurance, nursing home or long term care insurance, and specified disease insurance.

B. Medicare Supplemental Insurance

Medicare supplemental insurance policies, also known as "Medigap" policies, are designed to fill specific gaps in the original Medicare "fee-for-service" benefit structure. (They are not needed, and would not be usable, if Medicare benefits are obtained through an HMO or other type of managed care arrangement.) Medigap policies typically provide coverage for some or all of the deductible and coinsurance amounts applicable to Medicare-covered services, and sometimes cover items or services that are not covered by Medicare.

Section 1882 of the Act prohibits the sale of Medigap policies that do not conform to Federal statutory requirements. The statute also incorporates by reference, as part of the statutory requirements, certain minimum standards established by the National Association of Insurance Commissioners (NAIC). These minimum standards, known as the "NAIC Model Standards," are found in the "NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act," initially adopted by the NAIC on June 6, 1979. See section 1882(g)(2)(A) of the Act. In particular, the Model Standards, as revised in 1992 under the Omnibus Budget Reconciliation Act of 1990, prescribed 10 benefit packages. Under section 1882, Medigap policies generally may not be sold unless they conform to one of the 10 benefit packages, which are designated as plans "A" through "J."

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

States must amend their regulatory programs to implement all of the new Federal statutory requirements, and applicable changes to the Model standards. However, States maintain the authority to enact provisions that are more stringent than those that are incorporated in the NAIC Model

Regulation or in the statutory requirements. See section 1882(b)(1)(A) of the Act. States that have received a waiver under section 1882(p)(6) may continue to authorize the sale of policies that contain different benefits than the 10 standardized benefit packages. Massachusetts, Minnesota, and Wisconsin have received waivers; however, the three waiver States must still make the Balanced Budget Act of 1997 (BBA) conforming amendments. In particular, these States are subject to the statutory guaranteed issue requirements with respect to all Medicare beneficiaries who meet the criteria in section 1882(s)(3) for guaranteed issue. The only difference in the waiver States is that section 1882(3)(C)(iv) specifies that the statutory references to benefit packages (that is, in most cases, benefit packages designated "A", "B", "C" or "F") are deemed to be references to comparable benefit packages offered in the State with the waiver.

As provided in section 1882(p)(4)(B) of the Act, any State may continue to approve the addition of new or innovative benefits to an otherwise approved standardized plan.

Under section 1882(p)(5) of the Act, while a State must approve the core Plan "A" for sale in the State, it does not have to permit any or all of the other nine plans to be sold in the State. Therefore, the State need not permit the sale of each type of standardized plan, so long as the core plan is offered. Moreover, a State need not approve the sale of high deductible Plans "F" and "J" simply because it also permits sale of the standard deductible versions of either of these two plans.

In addition, section 1882(d) makes it unlawful in some circumstances for Medigap and certain other health insurance policies to be sold to a Medicare beneficiary if the sale results in duplicate coverage.

Section 1882(g)(1) of the Act defines Medicare supplemental policies. This definition excludes policies offered by an employer to employees or former employees and policies or plans offered by a labor organization to members or former members. HMOs, and other managed care plans that contract with Medicare under section 1876 of the Act or under a demonstration authority, as well as Medicare+Choice plans offered by organizations that contract under Part C of Medicare (see following discussion) are also excluded from the definition of a Medicare supplemental policy.

II. Legislative Changes

BBA created a new Part C of Medicare, commonly known as

Medicare+Choice. This allows Medicare eligible individuals to avail themselves of a wide range of managed care options. Under the new Medicare+Choice program, every individual entitled to Medicare Part A and enrolled under Part B, except for individuals with end-stage renal disease, may elect to receive benefits through either the existing Medicare fee-for-service program or a Part C Medicare+Choice plan. However, individuals choosing Medicare+Choice will not require the protections afforded under Medigap policies because their needs will be met under the Medicare+Choice program. Regulations for the new Part C Medicare+Choice program were published in a separate document on June 26, 1998 (63 FR 52610).

Section 4003(a)(1) of the BBA amended section 1882(d)(3)(A)(i) of the Act to provide that it is unlawful for a Medigap policy to be sold or issued to an individual who has elected to be enrolled in a Medicare+Choice plan when the seller has knowledge that the policy duplicates health benefits to which the individual is already entitled under Medicare+Choice or under another Medigap policy.

Section 4003(a)(3) of BBA also states that a Medicare+Choice plan is excluded from the definition of a Medicare supplemental policy.

Section 4031 of the BBA amended section 1882(s) of the Act, which governs guaranteed issue of Medigap policies. When an individual seeks to enroll in a specified Medigap policy within 63 days of the events described below, the issuer may not (1) deny or condition the issuance of a Medigap policy that is offered or available; (2) discriminate in the pricing of such a policy because of health status, claims experience, receipt of health care, or medical condition; or (3) impose a preexisting condition exclusion.

Involuntary Terminations of Coverage

For the following four classes of individuals, the specific policies subject to the guaranteed issue requirements are Medigap plans "A", "B", "C", or "F":

(a) Individuals enrolled under an employee welfare benefit plan that provides health benefits that supplement Medicare, if the plan terminates or ceases to provide all those benefits.

(b) Persons enrolled with a Medicare+Choice organization under a Medicare+Choice plan whose enrollment is discontinued under the following circumstances: (1) the organization's or plan's certification is terminated, or the organization has

discontinued providing the plan in the area where the person resides; (2) the individual is no longer eligible to remain in the plan because of a change in circumstances, including a move outside of the entity's service area, but not including nonpayment of premiums or disruptive behavior; or (3) the individual demonstrates that the organization substantially violated a material contract provision or materially misrepresented the plan's provisions in marketing the plan to the individual.

(c) Persons enrolled with an HMO or other organization that has a risk or cost contract under section 1876 of the Act; with a health care prepayment plan under section 1833 of the Act; with a similar organization operating under a demonstration project authority; or under a Medicare SELECT policy (a type of Medigap policy in which an individual's choice of providers is restricted in return for a lower Medigap insurance premium). However, this only applies if enrollment ceases for the reasons set forth in (b) above and, in the case of a SELECT policy, there is no applicable provision under State law for continuation of the coverage.

(d) Individuals enrolled under a Medigap policy if enrollment ceases because of: (1) Bankruptcy or insolvency of the issuer or because of other involuntary termination of coverage and there is no provision under applicable State law for the continuation of the coverage; (2) the issuer of the policy substantially violated a material provision of the policy; or (3) the issuer materially misrepresented the policy's provisions in marketing the policy to the individual. See section 4031(a)(3) of BBA.

Free Look at Managed Care

For the following class of individuals, the specific policies subject to the guaranteed issue requirements are the Medicare supplemental policy under which the individual was most recently enrolled if it is still available, or if this policy is not available from the previous issuer, Medigap plans "A," "B," "C," or "F." The following criteria must be met for the individual to qualify for guaranteed issue under this category: The individual (1) was covered under a Medigap policy; (2) subsequently terminated the policy and enrolled with a Medicare+Choice organization, with an HMO or other organization that has a contract under section 1876 of the Act, with a similar organization operating under a demonstration project authority, or purchased a Medicare SELECT policy; and (3) terminates enrollment in the Medicare+Choice or other organization, or the Medicare SELECT

policy, described in (2) within 12 months after enrolling. However, this provision applies only if the individual had never previously been enrolled with any organization or policy mentioned in (2) above.

For the five classes of Medicare beneficiaries described above, the guaranteed issue requirements protect "individuals" whose previous coverage has been terminated. Before the enactment of the BBA, beneficiaries had only one opportunity to purchase a Medigap policy on a "guaranteed issue" basis. This opportunity was only available to beneficiaries who were age 65 or over, and was available during the 6-month period following the date that they were both age 65 or over and enrolled in Medicare Part B. There was no guaranteed open enrollment provision for individuals under age 65. However, in contrast to both the general open enrollment provision of section 1882(s)(2)(A) and the new guaranteed issue provision in section 1882(s)(3)(B)(vi) (discussed below), which specifically state that the protected "individual" must be at least age 65, the guaranteed issue provisions in section 1882(s)(3)(B) (i) through (v) do not contain an age restriction.

Therefore, the latter provisions apply by their terms both to individuals eligible for Medicare based on age, and those whose eligibility is based on disability or ESRD. All of these individuals who meet the requirements set forth in the BBA qualify for its guaranteed issue protections with respect to policies that are offered and available to new enrollees. (In some situations policies may not be available to beneficiaries under 65. In other situations, a policy designated "B," "C," or "F" may not be available in a particular State.)

There is one additional class of beneficiaries who are entitled by the BBA amendments to a guaranteed issue Medigap policy. An individual who upon first becoming eligible for Medicare at age 65 enrolls in a Medicare+Choice plan, and later disenrolls from the plan within 12 months of the effective date of that enrollment, is entitled to guaranteed issue of any Medigap plan "A" through "J" under the same conditions described above (including that the individual must apply for the Medigap policy within 63 days of dropping the Medicare+Choice coverage, and may not be subject to a preexisting condition exclusion, or be subject to price discrimination based on health status).

Preexisting Condition Exclusion

Section 4031(b) of the BBA also limits the application of a preexisting

condition exclusion for Medigap policies during the initial 6-month open-enrollment period for aged beneficiaries. Such an exclusion cannot be imposed on an individual who, on the date of application, had a continuous period of at least 6 months of health coverage defined as "creditable coverage" under title XXVII of the Public Health Service (PHS) Act, as added by title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If the individual has less than 6 months coverage, the issuer must reduce the period of any preexisting condition exclusion by the aggregate of periods of "creditable coverage" applicable to the individual as of the enrollment date. The rules used to determine the reduction are based on rules used under section 2701 of the PHS Act.

The following information is provided for the convenience of the reader. A complete description of requirements under title XXVII of the PHS Act can be found at 45 CFR parts 144, 146, and 148. Under section 2701, a policy can only exclude coverage for a preexisting condition if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the six months before the effective date of the Medigap policy.

HIPAA also added section 2701(c) of title XXVII of the PHS Act to define creditable coverage as coverage of the individual under any of the following: group health plan; health insurance coverage; Part A or B of Medicare; Medicaid; a medical care program of the Indian Health Service or a tribal organization; a State health benefits risk pool; a public health plan; the health care program for active military personnel; the Federal employees health benefit plan; and a health benefit plan under the Peace Corps Act. However, creditable coverage does not include policies consisting solely of coverage of excepted benefits, as described below. Creditable coverage must be continuous. This means the individual must have no breaks in coverage of greater than 63 days. If the break is greater than 63 days, a new period begins after the individual reacquires creditable coverage. See section 2701(c)(2) of the PHS Act.

An individual may demonstrate creditable coverage in several ways. First, group health plans, health insurance issuers, and certain other entities must furnish a certificate of creditable coverage after the coverage terminates. In some cases this will be when employment ends; in other cases it will be after exhaustion of "continuation coverage" under the Consolidated Omnibus Budget

Reconciliation Act of 1985 (Public Law 99-272) or under a similar State program. A certificate may also be obtained upon request by the individual. See section 2701(c) of the PHS Act. Creditable coverage can also be demonstrated if the individual attests to the existence of creditable coverage, and presents corroborating evidence (such as pay stubs with insurance deduction or explanation of benefits, or verification by a physician or former health care provider that the individual had health care coverage). The individual must cooperate in verifying the information.

Excepted benefits as defined in section 2791(c) of the PHS Act means benefits under one or more of the following: accident or disability income insurance; a supplement to liability insurance; workers' compensation insurance; liability insurance such as automobile medical payment insurance or general liability insurance; credit-only insurance; on-site medical clinics and other similar insurance coverage, under which benefits for medical care are secondary or incidental to other insurance benefits.

Other excepted benefits, if offered separately, include: Limited scope dental or vision benefits, long-term care, nursing home care, home health care, community-based care, or any combination of these. Other excepted benefits, if offered as independent, noncoordinated benefits, include specified disease or illness coverage and hospital indemnity, or other fixed indemnity insurance. Medicare supplemental insurance is also classified as an excepted benefit.

Long Term Care Insurance Policies

Section 4031(c) of the BBA also clarifies, through a technical amendment, that certain disclosure requirements apply only to long-term care insurance policies that do not coordinate with Medicare and Medicaid.

High Deductible Medigap Standard Policies

Section 4032 of the BBA adds two additional high deductible Medigap standard policies with benefit packages that are the same as Plans "F" and "J." The high deductible amount is \$1,500 in 1998 and 1999. Out-of-pocket expenses, in this instance, are expenses that would ordinarily be paid by a Medigap policy. These expenses include the Medicare deductibles for Parts "A" and "B" but do not include, in Plan "J," the plan's separate prescription drug deductible of \$250 or, in Plans "F" and

"J," the plans" separate foreign travel emergency deductible of \$250.

For subsequent years, the high deductible amount will be increased by the percentage increase in the Consumer Price Index for all urban consumers (all items; U.S. city average) for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of \$10. The beneficiary is responsible for payment of all expenses up to this amount.

Treatment of Hospital Outpatient Department Copayment

Section 4031(f) of the BBA also specifies that "copayment" amounts provided for under section 1833(t)(5) of the Act with respect to hospital outpatient department services shall be treated under Medigap policies "in the same manner as coinsurance with respect to such services." We have therefore clarified the Model by including a reference to coverage for copayments for hospital outpatient department services in section 8.B(5) of the Model, and in the cover page of the outline of coverage that immediately follows section 17.C(4) of the Model. For purposes of complying with Federal law, States must use this revised language.

III. Dates

The provisions added by section 4031 of the BBA have a number of different effective dates, as established in section 4031(d). There has also been confusion about the effective date of the guaranteed issue provisions related to Medicare+Choice plans.

Guaranteed Issue Provisions

Section 4031(a) of the BBA expanded the number of opportunities in which an individual can enroll in a Medigap policy on a "guaranteed issue" basis. It added section 1882(s)(3)(B), clauses (i) through (vi), to the Act to require that certain Medigap policies be offered to six categories of beneficiaries in specific circumstances. Section 4031(d)(1) of the BBA makes these provisions effective July 1, 1998.

Clause (ii) assures that individuals enrolled in Medicare+Choice plans are entitled to guaranteed issue of Medigap policies "A," "B," "C," and "F" if "there are circumstances permitting discontinuance of the individual's election of the [Medicare+Choice] plan under the first sentence of section 1851(e)(4)." This language caused confusion because of its cross-reference to the Medicare+Choice provisions in section 1851(e)(4). The latter provision is a Medicare+Choice provision, not a Medigap provision. Under the

Medicare+Choice rules, starting in the year 2002, beneficiaries who elect to enroll in a Medicare+Choice plan will be subject to a "lock-in" provision. This means that they will only be able to change their Medicare+Choice election under certain circumstances. With certain exceptions, other than during an annual open enrollment period, individuals will not be able to change to other Medicare+Choice plans, or return to original, fee-for-service Medicare, except as described in section 1851(e)(4). Therefore, a beneficiary will not need a Medigap policy unless he or she is permitted to return to original Medicare. It is our understanding that the NAIC drafting note following section 12.B(2) of the Model was simply trying to explain to a "Medigap audience" why the Medigap requirement in clause (ii) cross-references a Medicare+Choice provision that will not itself be effective until 2002.

However, as a matter of Federal law, the guaranteed issue provision of clause (ii) takes effect July 1, 1998; continues in effect through and beyond 2002, and applies to any individual whose Medicare+Choice election terminates under the "circumstances" specified in subparagraphs (A) through (D) of section 1851(e)(4).

Clause (ii) of section 1882(s)(3)(B) conditions the right to a guaranteed issue Medigap policy on the "circumstances" that would (beginning in 2002) permit a beneficiary to change a Medicare+Choice election. These circumstances are contained in subparagraphs (A) through (D) of the first sentence of paragraph (e)(4). The clearest indication that this refers to the "circumstances" described in subparagraphs (A) through (D) of section 1851(e)(4), without incorporating the date that appears in the introductory clause of section 1851(e)(4), is that clause (iii) contains a virtually identical reference to "the circumstances that would permit discontinuance of an individual's election of coverage under the first sentence of section 1851(e)(4)." Clause (iii) applies to termination of Medicare managed care contracts under section 1876 of the Act. These contracts include "risk" contracts under section 1876, which cease to exist as of December 31, 1998, because they will be replaced by Medicare+Choice contracts. Therefore, clause (iii) only makes sense if it is interpreted to refer to the "circumstances" described in subparagraphs (A) through (D) of section 1851(e)(4), without the incorporation of the 2002 date.

On October 16, 1998, the NAIC's Medicare Supplement Working Group issued a Memorandum to all NAIC

members stating that it had recognized an inconsistency in the Model Regulation. The drafting note that follows subsection 12B(2), as adopted on April 29, 1998, stated that the guaranteed issue provisions do not become effective until January 1, 2002, for a person in a Medicare+Choice organization whose contract terminates. As discussed above, HCFA has determined, subsequent to the adoption of the Model Regulation by the NAIC, that this was a drafting inconsistency in the Model and that the provision became effective on July 1, 1998 along with the rest of the provisions. The NAIC has begun the process of amending the Model Regulation to eliminate the drafting error. Therefore, the Model Regulation, as set forth below, contains the corrected language as it has been proposed by the NAIC. For purposes of complying with Federal law, States must use this corrected language.

Other Provisions

Preexisting Condition Exclusions

The limit on preexisting condition exclusions added by section 4031(b) applies to policies issued on or after July 1, 1998. See section 4031(d) of the BBA.

Long-Term Care Provision

The long-term care policy disclosure provision (section 4031(c) of the BBA) is effective July 1, 1997, as if included in HIPAA. See section 4031(d)(3) of the BBA. For purposes of disclosure, policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

Changes to Conform to Medicare+Choice

The changes made by section 4003 of the BBA became effective on August 8, 1997, the date of enactment of the BBA.

Dates Applicable to Action by the NAIC

Section 4031(e)(2) of the BBA specified that if, within 9 months of enactment of the BBA, the NAIC modified its "Model Regulation" to conform to the BBA amendments, then the revised regulation would apply for purposes of section 1882. The NAIC adopted the revised standards on April 29, 1998.

Dates Applicable to Actions by the States

Each State is required to change its statutes or regulations to conform its regulatory program to the revised standards set forth in the NAIC Model Regulation, in order for Medigap

policies to continue to be sold in that State. This action generally must be taken within 1 year after the date of adoption of the revised NAIC standards, that is, by April 29, 1999. In general, a State will not be deemed out of compliance solely due to failure to make changes before that date. See section 4031(e)(1) of the BBA. The statute provides an exception for States that we identify as requiring new legislation to implement the standards but whose legislatures are not scheduled to meet in 1999 in a session at which these matters may be considered. See section 4031(e)(4)(B) of the BBA.

For States that fall within this exception, section 4031(e)(4)(B) of the BBA provides that a State will not be deemed out of compliance until the first day of the first quarter following the end of the first legislative session that begins on or after July 1, 1999. This section also provides that, in the case of a State that has a 2-year legislative session, each year of the session is deemed to be a separate regular session of the State legislature.

Accordingly, the standards in the Model Regulation apply to Medicare supplemental policies issued in a State on or after April 29, 1999, or an earlier date on which a State adopts the standards, unless the State of issuance has a legislature that does not meet during that timeframe.

Separate notification letters were sent to the States by HCFA regional offices. States should notify the regional offices by letter when the State law conforms to the NAIC model.

IV. Publication of List for Standardized Benefit Packages

We are publishing the list of standardized benefit packages, including Plans "F" and "J," which will now be available in standard as well as high deductible forms. The following is a summary of the coverages available. This list of standardized Medicare supplemental benefit packages is contained in section 9.E of the revised Model Regulation adopted by the NAIC on April 29, 1998, which is reprinted at the end of this notice. Section 16 of the Model Regulation includes a chart that outlines the benefits covered in each of the 10 standardized Plans "A" through "J."

Because it is necessary to refer to more than one section of the NAIC Model Regulation to determine the content of each standardized benefit package, we are providing the following summary of the 10 packages.

Plan "A" (Core Benefit Plan) (NAIC Model Section 9.E.(1))

The Core Benefit Plan includes the following:

- Coverage for the Part A coinsurance amount for day 61 through day 90 of hospitalization in each Medicare benefit period.
- Coverage for the Part A coinsurance amount for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100 percent of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime.
- Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood per calendar year.
- Coverage for the coinsurance amount for Part B services, or, in the case of hospital outpatient department services, the applicable copayment, (generally 20 percent of the approved amount) after the \$100 deductible is met. (Note that Plan A provides no coverage for benefits described in paragraphs (1) through (11) of NAIC Model Section 8.C.: the Part A inpatient hospital deductible (in 1998, \$764 for each Medicare benefit period; \$768 in 1999); the Part B deductible (\$100 each year); Part A coinsurance for post-hospital skilled nursing facility care; Part B charges in excess of Medicare-approved amounts; non-Medicare-covered prescription drugs, preventive services, at-home recovery services, or services received in a foreign country; or new or innovative benefits approved by the State insurance commissioner or by HCFA.)

Plan "B" (NAIC Model Section 9.E.(2))

- The core benefits; and
- The Part A inpatient hospital deductible.

Plan "C" (NAIC Model Section 9.E.(3))

- The core benefits;
- The Part A inpatient hospital deductible;
- The Part A coinsurance for post-hospital skilled nursing facility care for days 21 through 100 in a Medicare benefit period;
- The Part B annual deductible; and
- Eighty percent of charges for emergency care received in a foreign country during the first 60 days of a trip outside the U.S., subject to a \$250 calendar year deductible and a lifetime maximum benefit of \$50,000.

Plan "D" (NAIC Model Section 9.E.(4))

- The core benefits;

- The Part A inpatient hospital deductible;
- The Part A coinsurance for post-hospital skilled nursing facility care for days 21 through 100 in a Medicare benefit period;
 - Eighty percent of charges for emergency care received in a foreign country during the first 60 days of a trip outside the U.S., subject to a \$250 calendar year deductible and a lifetime maximum benefit of \$50,000; and
 - Services that are not covered by Medicare to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery, subject to limitations described in the NAIC Model.

Plan "E" (NAIC Model Section 9.E.(5))

- The core benefits;
- The Part A inpatient hospital deductible;
- The Part A coinsurance for post-hospital skilled nursing facility care for days 21 through 100 in a Medicare benefit period;
 - Eighty percent of charges for emergency care received in a foreign country during the first 60 days of a trip outside the U.S., subject to a \$250 calendar year deductible and a lifetime maximum benefit of \$50,000; and
 - Preventive health services not covered by Medicare, subject to a \$120 maximum annual benefit.

Plan "F" (NAIC Model Section 9.E.(6))

- The core benefits;
- The Part A inpatient hospital deductible;
- The Part A coinsurance for post-hospital skilled nursing facility care for days 21 through 100 in a Medicare benefit period;
 - The Part B annual deductible;
 - One hundred percent of Part B excess charges (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); and
 - Eighty percent of charges for emergency care received in a foreign country during the first 60 days of a trip outside the U.S., subject to a \$250 calendar year deductible and a lifetime maximum benefit of \$50,000.

Plan "F" High Deductible (NAIC Model Section 9.E.(7))

The high deductible plan pays the same or offers the same benefits as Plan "F" after the beneficiary has paid a calendar year deductible (\$1,500 in 1998 and 1999). Benefits from the high deductible Plan "F" will not begin until out-of-pocket expenses are equal to the

deductible (\$1,500). 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.

Plan "G" (NAIC Model Section 9.E.(8))

- The core benefits;
- The Part A inpatient hospital deductible;
- The Part A coinsurance for post-hospital skilled nursing facility care for days 21 through 100 in a Medicare benefit period;
 - Eighty percent of Part B excess charges (80 percent 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);
 - Eighty percent of charges for emergency care received in a foreign country during the first 60 days of a trip outside the U.S., subject to a \$250 calendar year deductible and a lifetime maximum benefit of \$50,000; and
 - Services that are not covered by Medicare to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery, subject to limitations described in the NAIC Model Regulation.

Plan "H" (NAIC Model Section 9.E.(9))

- The core benefits;
- The Part A inpatient hospital deductible;
- The Part A coinsurance for post-hospital skilled nursing facility care for days 21 through 100 in a Medicare benefit period;
 - Eighty percent of charges for emergency care received in a foreign country during the first 60 days of a trip outside the U.S., subject to a \$250 calendar year deductible and a lifetime maximum benefit of \$50,000; and
 - Fifty percent of outpatient prescription drug charges not covered by Medicare, subject to a \$250 calendar year deductible and a maximum \$1,250 in benefits per calendar year.

Plan "I" (NAIC Model Section 9.E.(10))

- The core benefits;
- The Part A inpatient hospital deductible;
- The Part A coinsurance for post-hospital skilled nursing facility care for days 21 through 100 in a Medicare benefit period;
 - One hundred percent of Part B excess charges (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);

- Eighty percent of charges for emergency care received in a foreign country during the first 60 days of a trip outside the U.S., subject to a \$250 calendar year deductible and a lifetime maximum benefit of \$50,000;
- Services that are not covered by Medicare to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery, subject to limitations described in the NAIC Model Regulation; and
- Fifty percent of outpatient prescription drug charges not covered by Medicare, subject to a \$250 calendar year deductible and a maximum \$1,250 in benefits per calendar year.

Plan "J" (NAIC Model Section 9.E.(11))

- The core benefits;
- The Part A inpatient hospital deductible;
- The Part A coinsurance for post-hospital skilled nursing facility care for days 21 through 100 in a Medicare benefit period;
 - The Part B annual deductible;
 - One hundred percent of Part B excess charges (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);
 - Eighty percent of charges for emergency care received in a foreign country during the first 60 days of a trip outside the U.S., subject to a \$250 calendar year deductible and a lifetime maximum of \$50,000;
 - Services that are not covered by Medicare to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery, subject to limitations described in the NAIC Model Regulation;
 - Fifty percent of outpatient prescription drug charges not covered by Medicare, subject to a \$250 calendar year deductible and a maximum \$3,000 in benefits per calendar year; and
 - Preventive health services not covered by Medicare, subject to a \$120 maximum annual benefit.

Plan "J"-High Deductible (NAIC Model Section 9.E.(12))

The high deductible plan pays the same or offers the same benefits as Plan "J" after a beneficiary has paid a calendar year deductible (\$1,500 in 1998 and 1999). Benefits from the high deductible Plan "J" will not begin until

out-of-pocket expenses are equal to the deductible (\$1,500). Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible, or the plan's separate foreign travel emergency deductible.

V. Regulatory Impact Statement

Consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), we prepare a regulatory flexibility analysis unless we certify that a notice will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, some insurance companies are considered to be small entities. Small entities are nonprofit organizations, local and municipal government entities, and entities defined by the Small Business Administration as small businesses (firms with fewer than 500 employees). Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a notice may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

Approximately 360 insurance companies offer Medigap policies. About half of the 360 insurance companies might be considered small entities.

All 50 States and the 360 insurance companies are affected by the revised standards described in this notice. Under these changes, insurers will now have to accept people in poorer health that the insurers could have rejected before. If there are delays before the insurance companies can raise rates to accommodate this change, or if the State does not let the insurance companies raise rates, there will be a cost to those companies. However, of the beneficiaries in poor health and meeting the criteria in the statute, we do not know how many of those who could have been rejected before will apply for Medigap insurance. As a result, we do not know the financial impact this may have on insurance companies selling Medigap insurance.

The costs of implementing the new NAIC standards will include the

codifying of changes in State insurance law or regulation to comply with the changes, and the modifying of insurance policies and notifying of the insured of the additional protections included in the changes to the NAIC Model Regulation. Any costs attributable to the NAIC regulatory changes are essentially mandated by the States, the Congress, and insurance companies.

There are benefits from the revised standards for Medicare beneficiaries. The additional protections will afford them increased access to Medigap insurance while providing separate opportunities to take advantage of the new Medicare+Choice program. Additionally, Medicare beneficiaries who enroll in the Medicare+Choice program but wish to leave the program, in many instances, will have the opportunity to reenroll in a Medigap policy if they choose to return to the traditional Medicare fee-for-service program.

This notice itself does not impose any requirements or result in costs or benefits. The purpose of the notice is to merely inform the public of the revised standards.

For these reasons, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this notice and the standards will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

In addition, this notice and the standards have been reviewed in accordance with the Unfunded Mandates Reform Act of 1995 (UMRA) (2 U.S.C. 1501 *et seq.*) and Executive Order 12875. We estimate that implementation of the new NAIC standards will not require the expenditure of more than \$100 million by the private sector. Therefore, we are not required to prepare a cost-benefit analysis of private sector expenditures, since this notice is not a significant regulatory action within the meaning of the UMRA.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

Authority: Section 1882 of the Social Security Act (42 U.S.C. 1395(ss)). (Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 24, 1998.

Nancy-Ann Min DeParle,
Administrator, Health Care Financing Administration.

Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act

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Section 1. Purpose

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

and sickness insurance coverages to persons eligible for Medicare.

Section 2. Authority

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

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

Section 3. Applicability and Scope

A. Except as otherwise specifically provided in Sections 7, 12, 13, 16 and 21, this regulation shall apply to:

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

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

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

Section 4. Definitions

For purposes of this regulation:

A. *Applicant* means:

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

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

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

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

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

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

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

(a) A group health plan;

(b) Health insurance coverage;

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

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

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

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

(g) A State health benefits risk pool;

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

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

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

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

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

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

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

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

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

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

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

(a) Limited scope dental or vision benefits;

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

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

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

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

(b) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

Drafting Note: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) specifically addresses separate, noncoordinated benefits in the group market at PHS § 2721(d)(2) and the individual market at § 2791(c)(3). HIPAA also references excepted benefits at PHS §§ 2701(c)(1), 2721(d), 2763(b) and 2791(c). In addition, creditable coverage will be addressed in regulations issued by the Secretary pursuant to HIPAA.

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

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

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

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

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

K. *Medicare+Choice plan* means a plan of coverage for health benefits under Medicare Part C as defined in [refer to definition of Medicare+Choice plan in Section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33], and includes:

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

and preferred provider organization plans;

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

(3) Medicare+Choice private fee-for-service plans.

L. *Medicare supplement policy* means a group or individual policy of [accident and sickness] insurance or a subscriber contract [of hospital and medical service associations or health maintenance organizations], other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et. seq.) or an issued policy under a demonstration project specified in 42 U.S.C. § 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

Drafting Note: OBRA 1990 contained an exception from this definition for policies issued pursuant to an agreement under Section 1833 (42 U.S.C. 1395l) of the federal Social Security Act. The Social Security Act Amendments of 1994 eliminated the exemption for Section 1833 plans effective December 31, 1995. These plans, commonly known as health care prepayment plans (HCPPs), arrange for certain Part B services on a pre-paid basis. The federal law continues to authorize HCPP agreements. However, since they are now included in the federal definition of a Medicare supplement policy, HCPPs are subject to the requirements of this model, unless they are exempt under Section 3B. In states authorized for the Medicare Select program, these plans may be able to comply with Medicare supplement requirements.

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

N. *Secretary* means the Secretary of the United States Department of Health and Human Services.

Section 5. Policy Definitions and Terms

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

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

(1) The definition shall not be more restrictive than the following: "Injury or

injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

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

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

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

D. *Health care expenses* means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

Expenses shall not include:

- (1) Home office and overhead costs;
- (2) Advertising costs;
- (3) Commissions and other acquisition costs;
- (4) Taxes;
- (5) Capital costs;
- (6) Administrative costs; and
- (7) Claims processing costs.

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

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

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

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

I. *Sickness* shall not be defined to be more restrictive than the following:

"Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force."

The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

Section 6. Policy Provisions

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

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

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

Section 7. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to [insert effective date adopted by state]

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

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

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

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting

condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

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

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

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

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

(4) A "noncancellable, "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

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

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

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

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

(i) An individual Medicare supplement policy currently offered by

the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(ii) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Section 8B of this regulation.

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

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

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

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

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

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

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

B. Minimum Benefit Standards.

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

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

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

(4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of

ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

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

(6) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [\$100];

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

Section 8. Benefit Standards for Policies or Certificates Issued or Delivered on or After [insert effective date adopted by state]

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after [insert effective date]. 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.

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

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

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

the Minimum Standards Model Act that recognizes the applicability of this preexisting condition rule to Medicare supplement policies and certificates.

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

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

(7) (a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder 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 certificateholder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

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

(c) Reinstitution of coverages:

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

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

(iii) Shall provide for classification of premiums on terms at least as favorable

to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

B. Standards for Basic (Core) Benefits Common to All Benefit Plans.

Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

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

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

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the diagnostic related group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

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

(5) Coverage for the coinsurance amount (or, in the case of hospital outpatient department services, the copayment amount) of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

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

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

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

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

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

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

(6) Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a \$250 calendar year deductible, to a maximum of \$1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(7) Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a \$250 calendar year deductible to a maximum of \$3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(8) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) Preventive Medical Care Benefit: Coverage for the following preventive health services:

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

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

- (1) Fecal occult blood test or digital rectal examination, or both;
- (2) Mammogram;

(3) Dipstick urinalysis for hematuria, bacteriuria and proteinuria;

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

(5) Serum cholesterol screening (every five (5) years);

(6) Thyroid function test;

(7) Diabetes screening.

(c) Influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster (every ten (10) years).

(d) Any other tests or preventive measures determined appropriate by the attending physician.

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

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

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

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

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

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

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

(b) Coverage Requirements and Limitations.

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

(ii) The insured's attending physician must certify that the specific type and

frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to:

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

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

(III) \$1,600 per calendar year;

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

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

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

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

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

(c) Coverage is excluded for:

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

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

(11) New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

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

Drafting Note: Use of new or innovative benefits may be appropriate to add coverage

or access to such benefits as prescription drugs, at-home recovery services and preventive medical care. Any such innovative benefit, however, should offer uniquely different or significantly expanded coverage.

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

Section 9. Standard Medicare Supplement Benefit Plans

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

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Section 8C(11) and in Section 10 of this regulation.

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

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

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

E. Make-up of benefit plans:

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

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

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

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

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

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

(7) Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections

8C (1), (2), (3), (5) and (8) respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be \$1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.

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

(9) Standardized Medicare supplement benefit plan "H" shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in Sections 8C (1), (2), (6) and (8) respectively.

(10) Standardized Medicare supplement benefit plan "I" shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in Sections 8C (1), (2), (5), (6), (8) and (10) respectively.

(11) Standardized Medicare supplement benefit plan "J" shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in Sections 8C (1), (2), (3), (5), (7), (8), (9) and (10) respectively.

(12) Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in Sections 8C (1), (2), (3), (5), (7), (8), (9) and (10) respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be \$1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.

Drafting Note: A state may determine by statute or regulation which of the above benefit plans may be sold in that state. The core benefit plan must be made available by all issuers. Therefore, the core benefit plan must be one of the authorized benefit plans adopted by a state. In no event, however, may a state authorize the sale of more than 10 standardized Medicare supplement benefit plans (that is, 9 plus the core policy), plus the two (2) high deductible plans, at the same time.

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

Section 10. Medicare Select Policies and Certificates

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

Drafting Note: This section should be adopted by states designated by the Secretary of Health and Human Services to participate in the Medicare Select Program. Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 (section 1882(t) of Title XVIII of the Social Security Act) authorized a three-year, fifteen-state program with states to be designated by the Secretary. Additional states may be authorized by future changes to federal law to apply the Medicare Select

Program requirements to existing preferred provider arrangements.

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

B. For the purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

(a) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-

hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

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

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

(ii) To make appropriate referrals.

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

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

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

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

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

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

(a) The formal organizational structure;

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

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

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

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

(7) Any other information requested by the commissioner.

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

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

G. A Medicare Select policy or certificate shall not restrict payment for

covered services provided by non-network providers if:

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

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

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

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

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

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

(b) Other Medicare Select policies or certificates.

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

(3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized.

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

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

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

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

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

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

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

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

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

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

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

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

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

M. (1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

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

N. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare

Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

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

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

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

Section 11. Open Enrollment

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

B. (1) If an applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the

issuer shall not exclude benefits based on a preexisting condition.

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

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

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

Section 12. Guaranteed Issue for Eligible Persons

A. Guaranteed Issue—(1) Eligible persons are those individuals described in subsection B who apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in subsection B, and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

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

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

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

supplemental health benefits to the individual;

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

(2) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, and any of the following circumstances apply:

(i) The organization's or plan's certification [under this part] has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(ii) 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;

(iii) 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

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

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

(i) An eligible organization under a contract under Section 1876 (Medicare risk or cost);

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

(iii) An organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or

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

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

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

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

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

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

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

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

Drafting Note: The reference to "insolvency of the issuer" in Paragraph 4(a) above is not required if there is a provision in state law or regulation that provides for the continuation or conversion of Medicare supplement policies or certificates. The reference to "substantially violated a material provision of the policy" in Paragraph 4(b) above is expected to be amplified by the Secretary when federal regulations are issued pursuant to the Balanced Budget Act of 1997 (P.L. 105-33).

(5) (a) The individual was enrolled under a Medicare supplement policy

and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, any eligible organization under a contract under Section 1876 (Medicare risk or cost), any similar organization operating under demonstration project authority, an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan), or a Medicare Select policy; and

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

(6) The individual, upon first becoming eligible for benefits under part A of Medicare at age 65, enrolls in a Medicare+Choice plan under part C of Medicare, and disenrolls from the plan by not later than twelve (12) months after the effective date of enrollment.

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

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

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

(2) Section 12B(5) is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Subsection C(1).

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

Drafting Note: Under federal law, for states that are exempted from standardization and offer benefit packages other than Plans A through J, the references to benefit packages above are deemed references to comparable benefit packages offered in that state. Those states should amend the language accordingly.

D. Notification provisions—(1) At the time of an event described in Subsection B of this section because of which an individual loses coverage or benefits due to the termination of a contract or

agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection A. Such notice shall be communicated contemporaneously with the notification of termination.

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

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

Section 13. Standards for Claims Payment

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

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

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

(3) Paying the participating physician or supplier directly;

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

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

(6) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to

which all claims may be sent by Medicare carriers.

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

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

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

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

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

(b) Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices.

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

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

Drafting Note: Subsection A(3) replicates language contained in the Omnibus Budget Reconciliation Act of 1990 (Pub. L. No. 101-508). It allows direct mail group policies sold on an individual basis to meet the minimum loss ratio required of individual business (65%) rather than that required of group business (75%). The NAIC eliminated this concept from this regulation in 1987 (I Proceedings of the NAIC, pp. 651, 673

(1988)). At that time, NAIC required direct mail group business to meet the same loss ratio requirement as other group business, regardless of whether the business was sold on an individual basis. The NAIC encourages states to apply the 75% loss ratio to all group business. Although NAIC is restricted from making revisions to its models that are not in conformance with OBRA 1990, states are free to impose more stringent requirements than OBRA.

(4) For policies issued prior to [insert effective date from Section 24 of this model, the effective date of the states regulation implementing the requirements of OBRA 1990], expected claims in relation to premiums shall meet:

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

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

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

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

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

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

(3) For the purposes of this section, policies or certificates issued prior to [insert effective date from Section 24 of this model, the effective date of the states regulation implementing the requirements of OBRA 1990], the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio

standard when issued) combined and all other group policies combined for experience after the [insert effective date of this amendment]. The first report shall be due by May 31, [insert (effective year + 2) of this amendment].

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

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

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

As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

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

necessary to justify the adjustment shall accompany the filing.

(b) An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

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

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

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

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

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

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

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

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

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

(a) The inclusion of new or innovative benefits;

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

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

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

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

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

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

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

The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

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

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

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

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

E. (1) Except as provided in Paragraph (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in [insert citation to Section 13 of NAIC Medicare Supplement Insurance Model Regulation].

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

Drafting Note: It has come to the attention of the NAIC that the use of attained age rating in the determination of rates in Medicare supplement policies may result in situations to which a regulatory response is desirable. States should assess their Medicare supplement marketplace to determine whether a regulatory response is needed. The following provisions may be included as a new subsection to Section 14. The first option prohibits insurers from attained age rating as a methodology for setting rates. The second option does not prohibit the use of attained age rating but requires Medicare supplement insurers who do use attained age rating as a rate setting methodology to apply the age component to its rates annually. The effective date of the regulation should provide sufficient time for insurers to re-rate approved policy forms in accordance with Section 14A and for the insurance department to approve (according to its rate filing practices and procedures), such re-ratings prior to the effective date of the regulation.

Option 1

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

Option 2

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

Section 16. Permitted Compensation Arrangements

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

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

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

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

Section 17. Required Disclosure Provisions

A. General Rules—(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums

and any automatic renewal premium increases based on the policyholder's age.

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

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

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

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

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

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

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

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

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

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

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

C. Outline of Coverage Requirements for Medicare Supplement Policies—(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant; and (2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name:

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

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

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

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page:
Benefit Plans _____ [insert letters of plans being offered]

Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in your state.

Basic Benefits: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), or, in the case of hospital outpatient department services, applicable copayments.

Blood: First three pints of blood each year.

A	B	C	D	E	F F*	G	H	I	J J*
Basic Benefits.	Basic Benefits Part A Deductible	Basic Benefits Skilled Nursing Co-Insurance Part A Deductible Part B Deductible Foreign Travel Emergency	Basic Benefits Skilled Nursing Co-Insurance Part A Deductible Foreign Travel Emergency At-Home Recovery	Basic Benefits Skilled Nursing Co-Insurance Part A Deductible Foreign Travel Emergency Preventive Care	Basic Benefits Skilled Nursing Co-Insurance Part A Deductible Part B Deductible Part B Excess (100%) Foreign Travel Emergency	Basic Benefits Skilled Nursing Co-Insurance Part A Deductible Part B Excess (80%) Foreign Travel Emergency At-Home Recovery	Basic Benefits Skilled Nursing Co-Insurance Part A Deductible Foreign Travel Emergency Basic Drugs (\$1,250 Limit)	Basic Benefits Skilled Nursing Co-Insurance Part A Deductible Foreign Travel Emergency At-Home Recovery Basic Drugs (\$1,250 Limit)	Basic Benefits Skilled Nursing Co-Insurance Part A Deductible Part B Excess (100%) Foreign Travel Emergency At-Home Recovery Extended Drugs (\$3,000 Limit) Preventive Care

* Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year \$1500 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are \$1500. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does not include, in plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.

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 "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer

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

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

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 9D of this regulation.]

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

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

Services	Medicare pays	Plan pays	You pay
Hospitalization *			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$[764]	\$0	\$[764] (Part A deductible)
61st thru 90th day	All but \$[191] a day	\$[191] a day	0
91st day and after:			
—While using 60 lifetime reserve days	All but \$[382] a day	\$[382] a day	0

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

Services	Medicare pays	Plan pays	You pay
—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 \$[95.50] a day	0	Up to \$[95.50] a day 3
101st day and after	0	0	All costs
Blood			
First 3 pints	0	3 pints	0
Additional amounts	100%	0	0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for out-patient drugs and inpatient respite care.	0	Balance

* 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.

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

Services	Medicare pays	Plan pays	You pay
Medical Expenses			
In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B deductible)
Remainder of Medicare Approved Amounts	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 \$100 of Medicare Approved Amounts*	0	0	\$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	0
Clinical Laboratory Services			
Blood tests for diagnostic services	100%	0	0

PARTS A & B

Services	Medicare pays	Plan pays	You pay
Home Health Care			
Medicare approved services:			
—Medically necessary skilled care services and medical supplies.	100%	0	0
—Durable medical equipment First \$100 of Medicare Approved Amounts*.	0	0	100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	0

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

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

Services	Medicare pays	Plan pays	You pay
Hospitalization *			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$[764]	\$[764](Part A deductible) ...	\$0
61st thru 90th day	All but \$[191] a day	\$[191] a day	0

PLAN B—MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD—Continued

Services	Medicare pays	Plan pays	You pay
91st day and after:			
—While using 60 lifetime reserve days	All but \$[382] a day	\$[382] 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 \$[95.50] a day	0	Up to \$[95.50] a day
101st day and after	0	0	All costs
Blood			
First 3 pints	0	3 pints	0
Additional amounts	100%	0	0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for out-patient drugs and inpatient respite care.	0	Balance

* 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.

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

Services	Medicare pays	Plan pays	You pay
Medical Expenses			
In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First \$100 of Medicare Approved Amounts.*	\$0	\$0	\$100 (Part B deductible)
Remainder of Medicare Approved Amounts	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 \$100 of Medicare Approved Amounts.*	0	0	100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	0
Clinical Laboratory Services			
Blood Test for Diagnostic Services	100%	0	0

PARTS A & B

Services	Medicare pays	Plan pays	You pay
Home Health Care			
Medicare approved services:			
Medically necessary skilled care services and medical supplies.	100%	0	0
Durable medical equipment			
First \$100 of Medicare Approved Amounts.*	0	0	100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	0

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

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

Services	Medicare pays	Plan pays	You pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$[764]	\$[764](Part A deductible) ...	\$0

PLAN C—MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD—Continued

Services	Medicare pays	Plan pays	You pay
61st thru 90th day	All but \$[191] a day	\$[191] a day	0
91st day and after:			
—While using 60 lifetime reserve days	All but \$[382] a day	\$[382] 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 \$[95.50] a day	Up to \$[95.50] a day	0
101st day and after	0	0	All costs
Blood			
First 3 pints	0	3 pints	0
Additional amounts	100%	0	0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	0	Balance

* 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.

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

Services	Medicare pays	Plan pays	You pay
Medical Expenses			
In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First \$100 of Medicare Approved Amounts *	\$0	\$100 (Part B deductible) ...	\$0
Remainder of Medicare Approved Amounts	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 \$100 of Medicare Approved Amounts *	0	100 (Part B deductible)	0
Remainder of Medicare Approved Amounts	80%	20%	0
Clinical Laboratory Services			
Blood tests for diagnostic services	100%	0	0

PARTS A & B

Home Health Care			
Medicare approved services;			
—Medically necessary skilled care services and medical supplies.	100%	0	0
—Durable medical equipment First \$100 of Medicare Approved Amounts *.	0	100 (Part B deductible)	0
Remainder of Medicare Approved Amounts	80%	20%	0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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	0

PLAN C—MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR—Continued

Services	Medicare pays	Plan pays	You pay
Remainder of Charges	0	80% to a lifetime maximum benefit of \$50,000.	20% and amounts over the \$50,000 lifetime maximum.

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

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

Services	Medicare pays	Plan pays	You pay
Hospitalization *			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$[764]	\$[764] (Part A deductible)	0
61st thru 90th day	All but \$[191] a day	\$[191] a day	0
91st day and after:			
—While using 60 lifetime reserve days	All but \$[382] a day	\$[382] a day \$0	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 \$[95.50] a day	Up to \$[95.50] a day	0
101st day and after	0	0	All costs
Blood			
First 3 pints	0	3 pints	0
Additional amounts	100%	0	0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	0	Balance

* 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.

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

Services	Medicare pays	Plan pays	You pay
Medical Expenses			
In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B deductible)
Remainder of Medicare Approved Amounts	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 \$100 of Medicare Approved Amounts*	0	0	\$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	0
Clinical Laboratory Services			
Blood tests for diagnostic services	100%	0	0

PARTS A & B

Services	Medicare pays	Plan pays	You pay
Home Health Care			
Medicare approved services:			

PLAN D—MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR—Continued

Services	Medicare pays	Plan pays	You pay
—Medically necessary skilled care services and medical supplies.	100%	0	0
—Durable medical equipment			
First \$100 of Medicare Approved Amounts*	0	0	100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	0
At-home recovery services—not covered by Medicare:			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan:			
—Benefit for each visit	0	Actual charges to \$40 a visit.	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit).	0	Up to the number of Medicare Approved visits, not to exceed 7 each week.	
—Calendar year maximum	0	1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

Services	Medicare pays	Plan pays	You pay
Foreign Travel—Not Covered by Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First \$250 each calendar year	0	0	250
Remainder of charges	0	80% to a lifetime maximum benefit of \$50,000.	20% and amounts over the \$50,000 lifetime maximum

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

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

Services	Medicare pays	Plan pays	You pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$[764]	\$[764] (Part deductible)	\$0
61st thru 90th day	All but \$[191] a day	\$[191] a day	0
91st day and after:			
—While Using 60 lifetime reserve days	All but \$[382] a day	\$[382] 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 \$[95.50] a day	Up to \$[95.50] a day	0
101st day and after	0	0	All costs
Blood			
First 3 pints	0	3 pints	0
Additional amounts	100%	0	0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care.	0	Balance

* 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.

PLAN E—MEDICARE (PART B)—MEDICAL SERVICES—PER BENEFIT PERIOD

Services	Medicare pays	Plan pays	You pay
Medical Expenses			
In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First \$100 of Medicare Approved Amounts ¹	\$0	\$0	\$100 (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 \$100 of Medicare Approved Amounts ¹	0	0	\$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	0
Clinical Laboratory Services			
Blood tests for diagnostic service	100%	0	0

PARTS A & B

Home Health Care			
Medicare approved services:			
Medically necessary skilled care services and medical supplies	100%	0	0
—Durable medical equipment First \$100 of Medicare Approved Amounts ¹ .	0	0	100 (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
Preventive Medical Care Benefit—Not Covered by Medicare ²			
Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare:			
First \$120 each calendar year	0	120	0
Additional charges	0	0	All costs

¹ Once you have been billed \$100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

² Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN F OR HIGH DEDUCTIBLE PLAN F—MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

Services	Medicare pays	After you pay \$1500 deductible, ² plan pays	In addition to \$1500 deductible, ² you pay
Hospitalization ¹			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$[764]	\$[764] (Part A deductible)	\$0
61st thru 90th day	All but \$[191] a day	\$[191] a day	0
91st day and after:			
While using 60 lifetime reserve days	All but \$[382] a day	\$[382] 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

PLAN F OR HIGH DEDUCTIBLE PLAN F—MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD—Continued

Services	Medicare pays	After you pay \$1500 deductible, ² plan pays	In addition to \$1500 deductible, ² you pay
Skilled Nursing Facility Care¹			
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 \$[95.50] a day	Up to \$[95.50] a day	0
101st day and after	0	0	All costs
Blood			
First 3 pints	0	3 pints	0
Additional amounts	100%	0	0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for out-patient drugs and inpatient respite care.	0	Balance

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

Medical Expenses			
In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First \$100 of Medicare approved amounts ¹	0	100 (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 \$100 of Medicare approved amounts ¹	0	100 (Part B deductible	0
Remainder of Medicare approved amounts	80	20%	0
Clinical Laboratory Services			
Blood tests for diagnostic services	100%	0	0

PARTS A & B

Home Health Care			
Medicare approved services:			
—Medically necessary skilled care services and medical supplies.	100%	0	0
—Durable medical equipment			
First \$100 of Medicare approved amounts ²	0	100 (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 life-time maximum

¹ 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.

² This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [\$1500] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$1500]. 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.

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

Services	Medicare pays	Plan pays	You pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$[764]	\$[764] (Part A deductible)	\$0
61st thru 90th day	All but \$[191] a day	\$[191] a day	0
91st day and after:			
—While using 60 lifetime reserve days	All but \$[382] a day	\$[382] a day	0
—Once lifetime reserve days are used:			
—Additional 365 days	0	100% of Medicare eligible expenses.	
—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 \$[95.50] a day	Up to \$[95.50] a day	0
101st day and after	0	0	All costs
Blood			
First 3 pints	0	3 pints	0
Additional amounts	100%	0	0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for out-patient drugs and inpatient respite care.	0	Balance

* 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.

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

Services	Medicare pays	Plan pays	You pay
Medical Expenses			
In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	0
Part B Excess Charges (Above Medicare Approved Amounts).	0	80%	20%
Blood			
First 3 pints	0	All costs	0
Next \$100 of Medicare Approved Amounts*	0	0	100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	0
Clinical Laboratory Services			
Blood tests for diagnostic services	100%	0	0

PARTS A & B

Home Health Care			
Medicare approved services:			
—Medically necessary skilled care services and medical supplies.	100%	0	0
—Durable medical equipment			
First \$100 of Medicare Approved Amounts*	0	0	100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	0
At-home recovery services—not covered by Medicare			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan:			
—Benefit for each visit	0	Actual charges to \$40 a visit.	Balance

PLAN G—MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR—Continued

Services	Medicare pays	Plan pays	You pay
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit).	0	Up to the number of Medicare-approved visits, not to exceed 7 each week.	
—Calendar year maximum	0	1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

Services	Medicare pays	Plan pays	You pay
Foreign Travel			
Not covered by Medicare:			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First \$250 each calendar year	0	0	250
Remainder of Charges	0	80% to a lifetime maximum benefit of \$50,000.	20% and amounts over the \$50,000 lifetime maximum.

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

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

Services	Medicare pays	Plan pays	You pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$[764]	\$[764] (Part A deductible)	\$0
61st thru 90th day	All but \$[191] a day	\$[191] a day	0
91st day and after:			
—While using 60 lifetime reserve days	All but \$[382] a day	\$[382] 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 \$[95.50] a day	Up to \$[95.50] a day	0
101st day and after	0	0	All costs
Blood			
First 3 pints	0	3 pints	0
Additional amounts	100%	0	0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for out-patient drugs and inpatient respite care.	0	Balance

* 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.

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

Services	Medicare pays	Plan pays	You pay
Medical Expenses			
In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	0
Part B Excess Charges (Above Medicare Approved Amounts).	0	0	All costs

PLAN H—MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR—Continued

Services	Medicare pays	Plan pays	You pay
Blood			
First 3 pints	0	All costs	0
Next \$100 of Medicare Approved Amounts*	0	0	100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	0
Clinical Laboratory Services			
Blood tests for diagnostic services	100%	0	0

PARTS A & B

Services	Medicare pays	Plan pays	You pay
Home Health Care			
Medicare Approved Services:			
—Medically necessary skilled care services and medical supplies.	100%	0	0
—Durable medical equipment			
First \$100 of Medicare Approved Amounts*	0	0	100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	0

OTHER BENEFITS—NOT COVERED BY MEDICARE

Services	Medicare pays	Plan pays	You pay
Foreign Travel			
Not covered by Medicare—Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First \$250 each calendar year	0	0	250
Remainder of charges	0	80% to a lifetime maximum benefit of \$50,000.	20% and amounts over the \$50,000 lifetime maximum
Basic Outpatient Prescription Drugs—Not Covered by Medicare			
First \$250 each calendar year	0	0	250
Next \$250 each calendar year	0	50%—\$1,250 calendar year maximum benefit.	50%
Over \$2,500 each calendar year	0	0	All costs

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

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

Services	Medicare pays	Plan pays	You pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$[764]	\$[764] (Part A deductible)	\$0
61st thru 90th day	All but \$[191] a day	\$[191] a day	0
91st day and after:			
—While using 60 lifetime reserve days	All but \$[382] a day	\$[382] 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 \$[95.50] a day	Up to \$[95.50] a day	0
1st day and after	0	0	All costs
Blood			
First 3 pints	0	3 pints	0
Additional amounts	100%	0	0

PLAN I—MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD—Continued

Services	Medicare pays	Plan pays	You pay
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for out-patient drugs and inpatient respite care.	0	Balance

* 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.

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

Services	Medicare pays	Plan pays	You pay
Medical Expenses			
In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First \$100 of Medicare Approved Amounts *	\$0	\$0	\$100 (Part B deductible)
Remainder of Medicare Approved Amounts	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 \$100 of Medicare Approved Amounts *	0	0	100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	0
Clinical Laboratory Services			
Blood test for diagnostic services	100%	0	0

PARTS A & B

Home Health Care			
Medicare Approved Services:			
—Medically necessary skilled care services and medical supplies.	100%	0	0
—Durable medical equipment			
First \$100 of Medicare Approved Amounts * ...	0	0	100 (Part B deductible)
Remainder of Medicare Approved Amounts ...	80%	20%	0
At-Home Recovery Services—Not Covered By Medicare—Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan:			
—Benefit for each visit	0	Actual charges to \$40 a visit.	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit).	0	Up to the number of Medicare-approved visits, not to exceed 7 each week.	
—Calendar year maximum	0	1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

Foreign Travel—Not Covered By Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First \$250 each calendar year	0	0	250
Remainder of charges	0	80% to a lifetime maximum benefit of \$50,000.	20% and amounts over the \$50,000 lifetime maximum
Basic Outpatient Prescription Drugs—Not Covered by Medicare			
First \$250 each calendar year	0	0	250
Next \$250 each calendar year	0	50%—\$1,250 calendar year maximum benefit.	50%

PLAN I—MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR—Continued

Services	Medicare pays	Plan pays	You pay
Over \$2,500 each calendar year	0	0	All costs

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

PLAN J OR HIGH DEDUCTIBLE PLAN J—MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

Services	Medicare pays	After you pay \$1500 deductible,** plan pays	In addition to \$1500 deductible,** you pay
Hospitalization *			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$[764]	\$[764] (Part A deductible)	\$0
61st thru 90th day	All but \$[191] a day	\$[191] a day	0
91st day and after:			
—While using 60 lifetime reserve days	All but \$[382] a day	\$[382] a day	0
—Once lifetime reserve days are used:			
—Additional 365 days	0	100% of Medicare eligible expenses.	
—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 \$[95.50] a day	Up to \$[95.50] a day	0
101st day and after	0	0	All costs
Blood			
First 3 pints	0	3 pints	0
Additional amounts	100%	0	0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for out-patient drugs and inpatient respite care.	0	Balance

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

** This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [\$1500] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [\$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

PLAN J OR HIGH DEDUCTIBLE PLAN J—MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

Services	Medicare pays	After you pay \$1500 deductible,** plan pays	In addition to \$1500 deductible,** you pay
Medical Expenses			
In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B deductible) ...	\$0
Remainder of Medicare Approved Amounts	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 \$100 of Medicare Approved Amounts.*	0	\$100 (Part B deductible) ...	0
Remainder of Medicare Approved Amounts	80%	20%	0
Clinical Laboratory Services			
Blood tests for diagnostic services	100%	0	0

PLAN J OR HIGH DEDUCTIBLE PLAN J—MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR—Continued

Services	Medicare pays	After you pay \$1500 deductible,** plan pays	In addition to \$1500 deductible,** you pay
PARTS A & B			
Home Health Care			
Medicare Approved Services:			
—Medically necessary skilled care services and medical supplies.	100%	0	0
—Durable medical equipment First \$100 of Medicare Approved Amounts *	0	100 (Part B deductible)	0
Remainder of Medicare Approved Amounts	80%	20%	0
At-home recovery services—not covered by Medicare—Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan:			
—Benefit for each visit	0	Actual charges to \$40 a visit.	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit).	0	Up to the number of Medicare Approved visits, not to exceed 7 each week.	
—Calendar year maximum	0	\$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

Foreign Travel—Not Covered by Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First \$250 each calendar year	0	0	250
Remainder of charges	0	80% to a lifetime maximum benefit of \$50,000.	20% and amounts over the \$50,000 lifetime maximum
Extended Outpatient Prescription Drugs—Not Covered by Medicare			
First \$250 each calendar year	0	0	250
Next \$6,000 each calendar year	0	50%—\$3,000 calendar year maximum benefit.	50%
Over \$6,000 each calendar year	0	0	All costs
***Preventive Medical Care Benefit—Not Covered by Medicare			
Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare:			
First \$120 each calendar year	0	120	0
Additional charges	0	0	All costs

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

** This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year \$1500 deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are \$1500. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

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

D. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

(1) Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. § 1395 *et seq.*), disability income policy; or other policy

identified in Section 3B of this regulation, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage

is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language:

“THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide

to Health Insurance for People with Medicare available from the company.”

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

Section 18. Requirements for Application Forms and Replacement Coverage

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

[Statements]

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

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

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

(4) The benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.

(5) 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]

To the best of your knowledge,

(1) Do you have another Medicare supplement policy or certificate in force?

(a) If so, with which company?

(b) If so, do you intend to replace your current Medicare supplement policy with this policy [certificate]?

(2) Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

(a) If so, with which company?

(b) What kind of policy?

(3) Are you covered for medical assistance through the state Medicaid program:

(a) As a Specified Low-Income Medicare Beneficiary (SLMB)?

(b) As a Qualified Medicare Beneficiary (QMB)?

(c) For other Medicaid medical benefits?

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

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

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

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

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

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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE [Insurance company's name and address]

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

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement 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 coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

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

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. 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.
 Other. (please specify)

1. 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.

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

Section 19. Filing Requirements for Advertising

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

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

Section 20. Standards for Marketing

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 21. Appropriateness of Recommended Purchase and Excessive Insurance

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

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

Section 22. Reporting of Multiple Policies

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

Medicare supplement policy or certificate:

- (1) Policy and certificate number, and
- (2) Date of issuance.

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

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

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

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

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

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

Section 24. Separability

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

Section 25. Effective Date

This regulation shall be effective on [insert date].

Appendix A—Medicare Supplement Refund Calculation Form for Calendar Year _____

TYPE 1

For the State of _____

NAIC Group Code _____
 Address _____
 Title _____
 SMSBP² _____
 Company Name _____
 NAIC Company Code _____
 Person Completing Exhibit _____
 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 (<i>see worksheet for Ratio 1</i>)		
8.	Experienced Ratio Since Inception (<i>Ratio 2</i>) 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)		

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

MEDICARE SUPPLEMENT 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.		

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

TYPE¹ _____
 SMSBP² _____
 For the State of _____
 Company Name _____
 NAIC Group Code _____
 NAIC Company Code _____
 Address _____
 Person Completing Exhibit _____
 Title _____
 Telephone Number _____

(a) ³	(b) ⁴	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) ⁵
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.0000		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

(a) ³	(b) ⁴	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) ⁵
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
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		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

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

¹ Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

² "SMSBP" = Standardized Medicare Supplement Benefit Plan—Use "P" for pre-standardized plans

³ Year 1 is the current calendar year—1. Year 2 is the current calendar year—2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

⁴ For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

⁵ These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

Reporting Form for the Calculation of Benchmark Ratio Since Inception for Individual Policies for Calendar Year _____

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

(a) ³	(b) ⁴	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) ⁵
Year	Earned premium	Factor	(b)x(c)	Cumulative loss ratio	(d)x(e)	Factor	(b)x(g)	Cumulative loss ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

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

¹ Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

² "SMSBP" = Standardized Medicare Supplement Benefit Plan—Use "P" for pre-standardized plans

³ Year 1 is the current calendar year—1. Year 2 is the current calendar year—2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

⁴ For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

⁵ These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

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.

Table with 2 columns: Policy and certificate #, Date of issuance

Signature _____

Name and Title (please type) _____

Date _____

Appendix C Disclosure Statements

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

- 1. Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy...
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements...
3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy...
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements.

The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

- Hospitalization
• Physician services
• Other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in all health insurance policies you already have.
✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[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
- Other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[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
- Other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[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
- Other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

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

[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
- Hospice
- Other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

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

This Is Not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

Medicare generally pays for most or all of these expenses.

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

- Hospitalization
- Physician services
- Hospice care
- Other approved items & services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

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

This Is Not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

- Hospitalization
- Physician services
- Hospice

- Other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[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
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[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
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[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

- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[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
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[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
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[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
- 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 Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[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
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Legislative History (All References Are to the Proceedings of the NAIC).

- 1980 Proc. II 22, 26, 588, 591, 593, 595–603 (adopted).
- 1981 Proc. I 47, 51, 420, 422, 424, 446–447, 470–481 (amended and reprinted).
- 1988 Proc. I 9, 20–21, 629–630, 652–654, 668–677 (amended and reprinted).
- 1988 Proc. II 5, 13, 568, 601, 604, 615–624 (amended and reprinted).
- 1989 Proc. I 14, 813–814, 836.4–836.26 (amended at special plenary session September 1988).
- 1989 Proc. I 9, 25, 703, 753–754, 757–760 (appendices amended at regular plenary session).
- 1990 Proc. I 6, 27–28, 477, 574–576, 580–599 (amended and reprinted).
- 1990 Proc. II 7, 16, 599, 656, 657 (adopted reporting form).
- 1992 Proc. I 12, 16–75, 1084–1085 (amended at special plenary session in July 1991).
- 1995 Proc. 1st Quarter 7, 12, 501, 575, 586, 592–615 (amended and most of model reprinted).
- 1995 Proc. 4th Quarter 11, 33, 889, 892 (amended).
- 1998 Proc. 1st Quarter (amended).

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health National Heart, Lung, and Blood Institute

Submission for OMB Review; Comment Request; Jackson Heart Study Participant Recruitment Survey

SUMMARY: Under the provisions of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the National Heart, Lung, and Blood Institute (NHLBI), the National Institutes of Health (NIH) has submitted to the Office of Management and Budget (OMB) a request to review and approve the

information collection listed below.

This proposed information was previously published in the **Federal Register** on August 11, 1998, pages 42864–42865 and allowed 60-days for public comment. No public comments were received. The purpose of this notice is to allow an additional 30 days for public comment. The National Institutes of Health may not conduct or sponsor, and the respondent is not required to respond to, an information collection that has been extended or implemented on or after October 1, 1995, unless it displays a currently valid OMB control number.

PROPOSED COLLECTION: *Title:* Jackson Heart Study Participant Recruitment Survey, Type of Information Collection Request: NEW. *Need and Use of Information Collection:* This survey will be used as a planning tool for the upcoming NHLBI-sponsored Jackson Heart Study. Participation and retention of African-Americans in observational epidemiologic studies has been much lower than for white populations. Experience with recruitment and retention of African-Americans in Jackson, Mississippi, is derived from the ongoing ARIC (Atherosclerosis Risk In Communities) study. Initial response was very low, with a 47 percent