

WEST VIRGINIA  
SECRETARY OF STATE  
KEN HECHLER  
ADMINISTRATIVE LAW DIVISION

Form #7

Do not mark in this box  
Filing Date

FILED

APR 2 4 05 PM '96

OFFICE OF WEST VIRGINIA  
SECRETARY OF STATE

Effective Date

May 3, 1996

NOTICE OF AN EMERGENCY RULE

AGENCY: Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY: W. Va. Code §§ 33-28-5b, 33-2-10, 33-16-3d, 33-24-4, 33-25A-20.

EMERGENCY AMENDMENT TO AN EXISTING RULE: YES  NO

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 24

TITLE OF RULE BEING AMENDED: Medicare Supplement Insurance

IF NO, SERIES NUMBER OF RULE BEING FILED AS AN EMERGENCY: \_\_\_\_\_

TITLE OF RULE BEING FILED AS AN EMERGENCY: \_\_\_\_\_

THE ABOVE RULE IS BEING FILED AS AN EMERGENCY RULE TO BECOME EFFECTIVE AFTER APPROVAL BY SECRETARY OF STATE OR 42ND DAY AFTER FILING, WHICHEVER OCCURS FIRST.

THE FACTS AND CIRCUMSTANCES CONSTITUTING THE EMERGENCY ARE AS FOLLOWS:

Use additional sheets if necessary

B. Keith Huffman  
Signature

15.50



STATE OF WEST VIRGINIA  
Offices of the Insurance Commissioner

Legal Division

GASTON CAPERTON  
Governor

HANLEY C. CLARK  
Insurance Commissioner

April 2, 1996

HAND DELIVERED

Ms. Judy Cooper, Director  
Administrative Law Division  
Office of Secretary of State  
State Capitol  
Charleston, West Virginia 25305

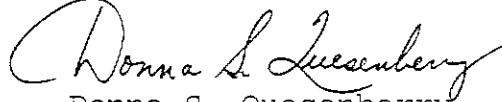
Dear Ms. Cooper:

Enclosed please find for filing fourteen (14) copies of the following:

- (1) Notice of an Emergency Rule;
- (2) Consent of Tax and Revenue Cabinet Secretary to Proposed Rule;
- (3) Brief Summary of Rule;
- (4) Legislative Rule-Making Review Committee Questionnaire;
- (5) Fiscal Note;
- (6) The proposed emergency rule titled "Medicare Supplement Insurance" (Series 24) which repeals and replaces the existing rule.

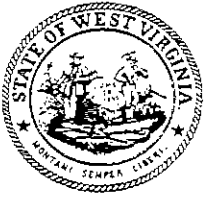
Please contact me if further information is required.

Very truly yours,

  
Donna S. Quesenberry  
Associate Counsel

DSQ/sar  
Enclosures

FILED  
APR 2 4 05 PM '96  
OFFICE OF WEST VIRGINIA  
SECRETARY OF STATE



STATE OF WEST VIRGINIA  
Offices of the Insurance Commissioner

Legal Division

GASTON CAPERTON  
Governor

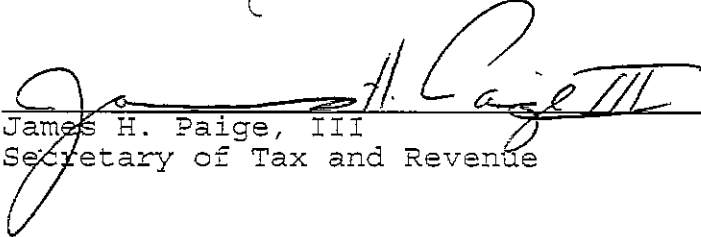
HANLEY C. CLARK  
Insurance Commissioner

CONSENT TO PROPOSAL OF RULE

To Whom It May Concern:

Pursuant to West Virginia Code § 5F-2-2(a)(12), the undersigned hereby grants consent to the proposal of the following rule proposed by the Insurance Commissioner of the State of West Virginia: Title 114, Series 24, relating to Medicare Supplement Insurance.

Signed this 27<sup>th</sup> day of March, 1996.

  
James H. Paige, III  
Secretary of Tax and Revenue

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: OFFICE OF THE INSURANCE COMMISSIONER

DATE: April 2, 1996

EMERGENCY RULE TITLE: MEDICARE SUPPLEMENT INSURANCE

(Title 114, Series 24)

1. Date of filing: April 2, 1996

2. Statutory authority for promulgating the emergency rule:  
W.Va. Code §§ 33-28-5B, 33-2-10, 33-26-3D, 33-24-4, 33-25a-20

3. Date of filing of proposed legislative rule: \_\_\_\_\_

4. Does the emergency rule adopt new language or does it amend or  
repeal a current legislative rule?  
Amends and repeals current legislative rule

5. Has the same or similar emergency rule previously been  
filed and expired?  
No

6. State, with particularity, those facts and circumstances  
which make the emergency rule necessary for the immediate  
preservation of public peace, health, safety or welfare.  
See next question

7. If the emergency rule was promulgated in order to comply with a time limit established by the Code or federal statute or regulation, cite the Code provision, federal statute or regulation and time limit established therein.

The emergency rule was promulgated in order to comply with the Social Security Act Amendments of 1994 (SSAA-94) which established new federal minimum standards for Medicare supplement policies. The State must promulgate this rule by April 28, 1996 to maintain approval as meeting federal minimum standards.

8. State, with particularity, those facts and circumstances which make the emergency rule necessary to prevent substantial harm to the public interest.

If the State fails to promulgate this rule by April 28, 1996, Medicare Supplement policies may not be sold in West Virginia after this date, unless the Secretary of the U.S. Department of Health and Human Services certifies that the policies meet the new federal standards.

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Medicare Supplement Insurance  
 Title 114, Series 24

Type of Rule:  Legislative  Interpretive  Procedural

Agency: Insurance Commissioner

Address: Post Office Box 50540  
 1124 Smith Street, Greenbrooke Building  
 Charleston, West Virginia 25305-0540

1. Effect of Proposed Rule

	ANNUAL FISCAL YEAR				
	Increase	Decrease	Current	Next	Thereafter
ESTIMATED TOTAL COST	\$ None				
PERSONAL SERVICES	None				
CURRENT EXPENSE	None				
REPAIRS AND ALTERNATIONS	None				
EQUIPMENT	None				
OTHER	None				

2. Explanation of above estimates:

There will be no fiscal impact on state, local or federal government.

3. Objectives of these rules:

The objective of this rule is to adopt current minimum federal standards for Medicare Supplement insurance policies, as set forth in the Social Security Act Amendments of 1994 (SSAA-94). The rule includes all of the federally mandated provisions to the National Association of Insurance Commissioners (NAIC) Model Regulation to implement the requirements of the Medicare Supplement Minimum Standards Model Act as required by SSAA-94.

Rule Title: Medicare Supplement Insurance  
Title 114, Series 24

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of Citizens.

The effect on the insurance industry will be negligible, as federal law already mandates the standards set by this rule for Medicare Supplement insurance, Medicare recipients will benefit economically by the rule's provisions on premiums and benefit levels for Medicare Supplement insurance policies.

C. Economic Impact on Citizens/Public at Large.

None.

Date: April 2, 1996

Signature of Agency Head or Authorized Representative

B. Keith Huffman

Insurance Commissioner  
Legislative Rule  
Title 114, Series 24

**MEDICARE SUPPLEMENT INSURANCE**

Title 114, Series 24

**BRIEF SUMMARY OF RULE**

This proposed rule adopts current minimum federal standards for Medicare Supplement insurance policies as mandated by the Social Security Act Amendments of 1994 (SSAA-94). This rule repeals and replaces the Insurance Commissioner's existing Series 24, and adopts the revisions to the 1991 National Association of Insurance Commissioners (NAIC) Model Regulation to implement the requirements of the Medicare Supplement Minimum Standards Model Act. States are required to make the requisite changes to their regulatory programs by April 28, 1996 to maintain approval as meeting minimum federal standards.

114CSR24

WEST VIRGINIA EMERGENCY RULE  
INSURANCE COMMISSIONER

SERIES 24  
MEDICARE SUPPLEMENT INSURANCE

Section

- 114-24-1. General.
- 114-24-2. Definitions.
- 114-24-3. Policy Definitions and Terms.
- 114-24-4. Policy Provisions.
- 114-24-5. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to August 5, 1991.
- 114-24-6. Benefit Standards for Policies or Certificates Issued or Delivered on or After August 5, 1991.
- 114-24-7. Standard Medicare Supplement Benefit Plans.
- 114-24-8. Medicare Select Policies and Certificates.
- 114-24-9. Open Enrollment.
- 114-24-10. Standards for Claims Payment.
- 114-24-11. Loss Ratio Standards and Refund or Credit of Premium.
- 114-24-12. Filing and Approval of Policies and Certificates and Premium Rates.
- 114-24-13. Permitted Compensation Arrangements.
- 114-24-14. Required Disclosure Provisions.
- 114-24-15. Requirements for Application Forms and Replacement Coverage.
- 114-24-16. Filing Requirements for Advertising.
- 114-24-17. Standards for Marketing.

114-24-18. Appropriateness of Recommended Purchase and Excessive Insurance.

114-24-19. Reporting of Multiple Policies.

114-24-20. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates.

114-24-21. Severability.

Appendix A. Medicare Supplement Refund Calculation Form.

Appendix B. Outline of Medicare Supplement Coverage-- Cover Page.

Appendix C. Medicare Supplement Benefit Plans "A" through "J", Respectively (26 pages).

Appendix D. Form for Reporting Medicare Supplement Policies.

Appendix E. Outline of Medicare Supplement Coverage and Premium Information.

Appendix F. Notice to Applicant Regarding Replacement of Medicare Supplement Insurance.

TITLE 114  
WEST VIRGINIA EMERGENCY RULE  
INSURANCE COMMISSIONER

SERIES 24  
MEDICARE SUPPLEMENT INSURANCE

FILED  
APR 2 4 05 PM '96  
OFFICE OF WEST VIRGINIA  
SECRETARY OF STATE

§ 114-24-1. General.

1.1. Scope. -- 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.

1.2. Authority. -- W. Va. Code §§ 33-28-5b, 33-2-10, 33-16-3d, 33-24-4, and 33-25A-20.

1.3. Filing Date. --

1.4. Effective Date. --

1.5. Applicability. -- This emergency rule repeals and replaces West Virginia 114CSR24 "Permanent Regulations on Medicare Supplement Insurance" filed June 18, 1993 and effective on June 18, 1993. Except as otherwise specifically provided, this regulation shall apply to:

a. All Medicare supplement policies delivered or issued for delivery in this State or which are otherwise subject to the jurisdiction of this State on or after the effective date hereof; and

b. All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this State.

c. 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 a 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.

§ 114-24-2. Definitions.

2.1. "Applicant" means:

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

a. in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

b. in the case of a group Medicare supplement policy, the proposed certificateholder.

2.2. "Certificate" means any certificate delivered or issued for delivery in this State under a group Medicare supplement policy.

2.3. "Certificate Form" means the form on which the certificate is delivered or issued for delivery by the issuer.

2.4. "Commissioner" means the Insurance Commissioner of the State of West Virginia.

2.5. "Issuer" means insurance company, fraternal benefit society, health care service plan, health maintenance organization, or any other entity delivering or issuing for delivery in this State Medicare supplement policies or certificates.

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

2.7. "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 corporations 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.

2.8. "Policy Form" means the form on which the policy is delivered or issued for delivery by the issuer.

§ 114-24-3. Policy Definitions and Terms.

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

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

section.

3.2. "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.

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

b. Such 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.

3.3. "Benefit Period" or "Medicare Benefit Period" shall not be defined more restrictively than as defined in the Medicare program.

3.4. "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall not be defined more restrictively than as defined in the Medicare program.

3.5. "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. Such expenses shall not include:

- a. Home office and overhead costs;
- b. Advertising costs;
- c. Commissions and other acquisition costs;
- d. Taxes;
- e. Capital costs;
- f. Administrative costs; and
- g. Claims processing costs.

3.6. "Hospital" may be defined in relation to its status,

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

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.

3.7. "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.

3.8. "Medicare Eligible Expenses" shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

3.9. "Physician" shall not be defined more restrictively than as defined in the Medicare program.

3.10. "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.

§ 114-24-4. Policy Provisions.

4.1. Except for permitted preexisting condition clauses as described in Paragraph a of Subsection 5.2 and Paragraph a of Subsection 6.2 of this regulation, no policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

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

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

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

§ 114-24-5. Minimum Benefit Standards for Policies or  
Certificates Issued for Delivery Prior to August  
5, 1991.

5.1. 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 minimum standards set forth in this section. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

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

a. 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.

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

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premium modifications to correspond to such changes are permissible subject to prior approval of the commissioner. Any such proposed premium modifications shall be filed with the commissioner in compliance with procedures applicable to accident and sickness filings generally and with other applicable sections of these regulations.

d. 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

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

B. be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

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

A. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Subparagraph C of this Paragraph, the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:

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

(b) an individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Subsection 6.3 of this regulation.

B. If membership in a group is terminated, the issuer shall:

(a) offer the certificateholder such conversion opportunities as are described in Subparagraph B of this Paragraph; or

(b) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

C. 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.

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

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.

5.3. Minimum Benefit Standards.

a. 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;

b. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

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

d. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 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;

e. 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;

f. 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];

g. 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.

§ 114-24-6. Benefit Standards for Policies or Certificates  
Issued or Delivered on or After August 5, 1991.

6.1. The standards set forth in this section are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this State on or after August 5, 1991. No policy or certificate may be advertised, solicited, delivered or

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

issued for delivery in this State as a Medicare supplement policy or certificate unless it complies with these benefit standards.

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

a. 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.

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

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premium modifications to correspond to such changes are permissible subject to prior approval of the commissioner. Any such proposed premium modifications shall be filed with the commissioner in compliance with procedures applicable to accident and sickness filings generally and with other applicable sections of these regulations.

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

e. Each Medicare supplement policy shall be guaranteed renewable and

A. The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

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

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

C. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Subparagraph E of this Paragraph, the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):

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

(b) Provides for such benefits as 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

(a) Offer the certificateholder the conversion opportunity described in Subparagraph C of this Paragraph, or

(b) 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.

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

g. 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

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance.

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

B. Reinstitution of such coverages:

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

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

(c) 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.

6.3. 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 thereof.

a. 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;

b. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

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;

d. 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;

e. Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

6.4. Standards for Additional Benefits. --- The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 7 of this regulation.

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

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

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

d. Eighty 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.

e. 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.

f. Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

deductible, to a maximum of one thousand two hundred fifty dollars (\$1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

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

h. 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 two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$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.

i. 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 of this Paragraph 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:

(a) Fecal occult blood test and/or digital rectal examination;

(b) Mammogram;

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

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

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

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

(f) Thyroid function test;

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

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

A. For purposes of this benefit, the following definitions shall apply:

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

(b) "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 24-hour period of services provided by a care provider is one visit.

(c) "Care provider" means a duly qualified or licensed home health aide/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.

(d) "Home" shall mean any place used by the

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

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

B. Coverage Requirements and Limitations

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

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

(c) Coverage is limited to:

(A) 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;

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

(C) One thousand six hundred dollars (\$1,600) per calendar year;

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

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

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

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

(H) 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:

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

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

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

k. 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. Such 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.

§ 114-24-7. Standard Medicare Supplement Benefit Plans.

7.1. 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 Subsection 6.3 of this regulation.

7.2. 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 Paragraph k of Subsection 6.4 and in Section 8, [\*Section 8 of this regulation will not take effect until West Virginia is designated a Medicare Select State by the federal government], of this regulation.

7.3. 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 2 of this regulation. Each benefit shall be structured in accordance with the format provided in Subsections 6.3 and 6.4 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.

7.4. An issuer may use, in addition to the benefit plan designations required in Subsection 7.3, other designations to the extent permitted by law.

7.5. Make-up of benefit plans:

a. Standardized Medicare supplement benefit plan "A" shall be limited to the Basic ("Core") Benefits Common to All

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

Benefit Plans, as defined in Subsection 6.3 of this regulation.

b. Standardized Medicare supplement benefit plan "B" shall include only the following: The Core Benefit as defined in Section 6.3 of this regulation, plus the Medicare Part A Deductible as defined in Paragraph a of Subsection 6.4.

c. Standardized Medicare supplement benefit plan "C" shall include only the following: The Core Benefit as defined in Section 6.3 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 Paragraphs a, b, c and h of Subsection 6.4 respectively.

d. Standardized Medicare supplement benefit plan "D" shall include only the following: The Core Benefit as defined in Section 6.3 of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit as defined in Paragraphs a, b, h and j of Subsection 6.4 respectively.

e. Standardized Medicare supplement benefit plan "E" shall include only the following: The Core Benefit as defined in Section 6.3 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 Paragraphs a, b, h and i of Subsection 6.4 respectively.

f. Standardized Medicare supplement benefit plan "F" shall include only the following: The Core Benefit as defined in Section 6.3 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 Paragraphs a, b, c, e and h of Subsection 6.4 respectively.

g. Standardized Medicare supplement benefit plan "G" shall include only the following: The Core Benefit as defined in Section 6.3 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 Paragraphs a, b, d, h and j of Subsection 6.4 respectively.

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

h. Standardized Medicare supplement benefit plan "H" shall consist of only the following: The Core Benefit as defined in Section 6.3 of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Outpatient Prescription Drug Benefit, and Medically Necessary Emergency Care in a Foreign Country as defined in Paragraph a, b, f and h of Subsection 6.4 respectively.

i. Standardized Medicare supplement benefit plan "I" shall consist of only the following: The Core Benefit as defined in Section 6.3 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 Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in Paragraph a, b, e, f, h and j of Subsection 6.4 respectively.

j. Standardized Medicare supplement benefit plan "J" shall consist of only the following: The Core Benefit as defined in Section 6.3 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 and At-Home Recovery Benefit as defined in Paragraphs a, b, c, e, g, h, i and j of Subsection 6.4 respectively.

**§ 114-24-8. Medicare Select Policies and Certificates.**

[\*Section 8 of this regulation will not take effect until West Virginia is designated a Medicare Select State by the federal government.]

8.1. This section shall apply to Medicare Select policies and certificates, as defined in this section.

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

8.3. For the purposes of this section:

a. "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

b. "Grievance" means dissatisfaction expressed in

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

c. "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

d. "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

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

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

g. "Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

8.4. 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.

8.5. 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.

8.6. 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:

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

A. Such 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

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

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:

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

(b) 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 such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

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

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

d. A description of the quality assurance program, including:

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.

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

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

f. Copies of the written information proposed to be used by the issuer to comply with Subsection 8.10.

g. Any other information requested by the commissioner.

8.7. A Medicare Select issuer shall file:

a. Any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing such changes. Such changes shall be considered approved by the commissioner after thirty (30) days unless specifically disapproved.

b. An updated list of network providers with the commissioner at least quarterly.

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

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

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

8.9. 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.

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

a. An outline of coverage 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.

b. A description (including address, phone number and

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

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

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

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

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

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

8.11. 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 8.10 of this Section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

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

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

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

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

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

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

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

f. The issuer shall report no later than each March 31 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.

8.13. 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.

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

a. 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 outpatient prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

8.15. 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.

a. Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

b. For the purposes of 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 outpatient prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

8.16. 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.

§ 114-24-9. Open Enrollment.

9.1. No issuer shall 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 such 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.

9.2. Except as provided in Section 20, Subsection 9.1 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.

§ 114-24-10. Standards for Claims Payment.

10.1. An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub.

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

L. No. 100-203) by:

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

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

c. Paying the participating physician or supplier directly;

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

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

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

10.2. Compliance with the requirements set forth in Section 10.1 above shall be certified on the Medicare supplement insurance experience reporting form.

§ 114-24-11. Loss Ratio Standards and Refund or Credit of Premium.

11.1. Loss Ratio Standards.

a. A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless:

A. 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 certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(a) At least 75 percent of the aggregate amount of premiums earned in the case of group policies, or

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

(b) At least 65 percent 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 such period and in accordance with accepted actuarial principles and practices.

b. 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.

c. For purposes of applying Part (a), Subparagraph A, Paragraph a of Subsection 11.1 and Paragraph b of Subsection 12.3 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.

d. For policies issued prior to the effective date of this rule, 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 Parts (a) and (b), Subparagraph A, Paragraph a of Subsection 11.1 when combined with actual experience beginning with the effective date of this rule; and

C. The appropriate loss ratio requirement from Parts (a) and (b), Subparagraph A, Paragraph a of Subsection 11.1 over the entire future period for which the rates are computed to provide coverage.

11.2. Refund or Credit Calculation.

a. 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. Appendix A, which is hereby incorporated into this regulation by reference,

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

is annexed hereto and entitled "Reporting Form for Calculation of Loss Ratios."

b. 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.

c. For the purposes of this section, policies or certificates issued prior to the effective date of this rule, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after the effective date of this rule. The first such report shall be due by May 31, 1998.

d. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such 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 13-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.

### 11.3. Annual filing of premium rates.

a. An issuer of Medicare supplement policies and certificates issued before or after the effective date of these "Permanent Regulations on Medicare Supplement Insurance" 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. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

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

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

(a) An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with 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 such Medicare supplement insurance policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein should be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(b) 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.

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

11.4. Public Hearings.

a. 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 these "Permanent Regulations on Medicare Supplement Insurance" if the experience of the form for the previous reporting period is not in

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner consistent with the provisions of W. Va. Code §§ 33-2-12 and 33-2-13. Nothing in this subsection shall be construed so as to limit the authority of the commissioner to conduct hearings regarding rates, to the extent that the laws of this State grant such authority.

§ 114-24-12. Filing and Approval of Policies and Certificates and Premium Rates.

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

12.2. 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.

12.3. Except as provided in Paragraph a 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.

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

- 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.

b. 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. [\*These provisions

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

regarding Medicare Select policies will not take effect until West Virginia is designated a Medicare Select State by the federal government.]

12.4. Except as provided in Subparagraph A, Paragraph a of this Subsection, 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.— A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months.

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 of Paragraph a of this Subsection 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.

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

c. A change in the rating structure or methodology shall be considered a discontinuance under Subsection 12.4 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

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

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.

12.5. Refund or Credit Calculation.

a. Except as provided in Paragraph b of this Subsection, 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 Section 11.

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

§ 114-24-13. Permitted Compensation Arrangements.

13.1. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is not greater than the commission or other compensation paid for selling or servicing the policy or certificate during each of the next four years or periods of the policy.

13.2. Beginning with the sixth year or period of the policy or certificate and for each year or period thereafter, the agent or producer shall receive no commission or compensation other than a maximum ten percent (10%) maintenance or service fee per policy year or period.

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

13.4. 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 finder's fees.

§ 114-24-14. Required Disclosure Provisions.

14.1. General Rules.

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

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

b. 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 the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

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

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

e. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or 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.

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

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

14.2. Notice Requirements.

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

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

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

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

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

14.3. Outline of Coverage Requirements for Medicare Supplement Policies.

a. Issuers shall provide an outline of coverage to all

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of such outline from the applicant; and

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

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

c.— 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 Medicare Supplement Benefit Plans "A" through "J" shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

d. The following items shall be included in the outline of coverage in the order prescribed in Appendix E at the end of this rule. Appendix B, entitled "Outline of Medicare Supplement Coverage--Cover Page," which is incorporated into this regulation by reference and annexed hereto, prescribes the information to be contained on the cover page. The required premium information and disclosure pages are in Appendix E of this regulation. Examples of charts displaying the features of each Medicare supplement benefit plan offered by the issuer is contained in Appendix C, which is annexed hereto and incorporated herein by reference.

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

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

a. 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 Paragraph c of Subsection 1.5 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."

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

§ 114-24-15. Requirements for Application Forms and Replacement Coverage.

15.1. 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 accident and sickness 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.

a. Statements:

A. You do not need more than one Medicare supplement policy.

B. If you purchase this policy, you may want to

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

evaluate your existing health coverage and decide if you need multiple coverages.

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

D. 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.

E. 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).

b. Questions:

A. To the best of your knowledge:

(a) 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]?

(b) 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?

(c) Are you covered for medical assistance through the State Medicaid program:

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

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

(QMB)? (B) As a Qualified Medicare Beneficiary  
(C) For other Medicaid medical  
benefits?

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

a. List policies sold which are still in force.

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

15.3. 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.

15.4. 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 (1) copy of such notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant, at the time of the issuance of the policy, the notice regarding replacement of Medicare supplement coverage.

15.5. The notice required by Subsection 15.4 for an issuer shall be provided in substantially the form at the end of this rule (Appendix F) in no less than twelve (12) point type.

15.6. 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.

§ 114-24-16. Filing Requirements for Advertising.

16.1. 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 for review. Such advertisement shall comply with all laws of this State, including, when applicable, the provisions of W. Va.

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

Code §§ 33-6-8(e), 33-6-35, and 33-11-4(2).

§ 114-24-17. Standards for Marketing.

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

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

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

c. Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

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

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

e. Establish auditable procedures for verifying compliance with this Subsection 17.1.

17.2. In addition to the practices prohibited in this State's Unfair Trade Practices Act [W. Va. Code § 33-11-1 et seq.], the following acts and practices are prohibited:

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

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

c. Cold lead advertising. -- Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

solicitation of insurance and that contact will be made by an insurance agent or insurance company.

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

**§ 114-24-18. Appropriateness of Recommended Purchase and Excessive Insurance.**

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

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

**§ 114-24-19. Reporting of Multiple Policies.**

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

- a. Policy and certificate number, and
- b. Date of issuance.

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

19.3. To comply with this section, an issuer shall use the form incorporated herein by reference and annexed hereto as Appendix D, entitled "Form for Reporting Duplicate Policies."

**§ 114-24-20. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates.**

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

Insurance Commissioner  
Emergency Rule  
Title 114, Series 24

policy.

20.2. 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.

§ 114-24-21. Severability.

21.1. 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.

MEDICARE SUPPLEMENT REFUND CALCULATION FORM  
FOR CALENDAR YEAR \_\_\_\_\_

TYPE<sup>1</sup> \_\_\_\_\_  
For the State of \_\_\_\_\_  
NAIC Group Code \_\_\_\_\_  
Address \_\_\_\_\_  
Title \_\_\_\_\_

SMSBP<sup>2</sup> \_\_\_\_\_  
Company Name \_\_\_\_\_  
NAIC Company Code \_\_\_\_\_  
Person Completing Exhibit \_\_\_\_\_  
Telephone Number \_\_\_\_\_

<u>Line</u>	(a) Earned Premium <sup>3</sup>	(b) Incurred Claims <sup>4</sup>
1. Current Year's Experience		
a. Total (all policy years)	_____	_____
b. Current year's issues <sup>5</sup>	_____	_____
c. Net (for reporting purposes=1a-1b)	_____	_____
2. Past Years' Experience (all policy years)	_____	_____
3. Total Experience (Net Current Year + Past Year)	_____	_____
4. Refunds Last Year (Excluding Interest)		_____
5. Previous Since Inception (Excluding Interest)		_____
6. Refunds Since Inception (Excluding Interest)		_____
7. Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1)		_____
8. Experienced Ratio Since Inception Total Actual Incurred Claims (line 3, col. b) = Ratio 2/ 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 year exposure, then proceed to calculation of refund.		_____
10. Tolerance Permitted (obtained from Credibility Table)		_____

Medicare Supplement Credibility Table  
Life Years Exposed

<u>Since Inception</u>	<u>Tolerance</u>
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.	

<sup>1</sup> Individual Group, Individual Medicare Select, or Group Medicare Select Only.

<sup>2</sup> "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

<sup>3</sup> Includes Modal Loadings and Fees Charged

<sup>4</sup> Excludes Active Life Reserves

<sup>5</sup> This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

MEDICARE SUPPLEMENT REFUND CALCULATION FORM  
FOR CALENDAR YEAR \_\_\_\_\_

TYPE<sup>1</sup> \_\_\_\_\_  
For the State of \_\_\_\_\_  
NAIC Group Code \_\_\_\_\_  
Address \_\_\_\_\_  
Title \_\_\_\_\_

SMSBP<sup>2</sup> \_\_\_\_\_  
Company Name \_\_\_\_\_  
NAIC Company Code \_\_\_\_\_  
Person Completing Exhibit \_\_\_\_\_  
Telephone Number \_\_\_\_\_

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

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

12. Adjusted Incurred Claims  
[Total Earned Premiums (line 3, col. a) - Refunds since Inception (line 6)] X Ratio 3 (line 11) \_\_\_\_\_

13. Refund  
Total Earned Premiums (line 3, col. a) - Refunds Since Inception  
(line 6) - Adjusted Incurred Claims (line 12)/  
Benchmark Ratio (Ratio 1) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name - Please Type

\_\_\_\_\_  
Title - Please Type

\_\_\_\_\_  
Date

**REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION  
FOR INDIVIDUAL POLICIES FOR CALENDAR YEAR**

TYPE<sup>1</sup> \_\_\_\_\_  
 For the State of \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_  
 Address \_\_\_\_\_  
 Title \_\_\_\_\_

SMSBP<sup>2</sup> \_\_\_\_\_  
 Company Name \_\_\_\_\_  
 NAIC Company Code \_\_\_\_\_  
 Person Completing Exhibit \_\_\_\_\_  
 Telephone Number \_\_\_\_\_

(a) <sup>3</sup> Year	(b) <sup>4</sup> Earned Premium	(c) Factor	(d) (b)(c)	(e) Cumulative Loss Ratio	(f) (d)(e)	(g) Factor	(h) (b)(g)	(i) Cumulative Loss Ratio	(j) (h)(j)	(k) 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<sup>2</sup> = 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 GROUP POLICIES FOR CALENDAR YEAR**

TYPE<sup>1</sup> \_\_\_\_\_ SMSBP<sup>2</sup> \_\_\_\_\_  
 For the State of \_\_\_\_\_ Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_ Person Completing Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

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

Benchmark Ratio Since Inception:  $(1+n)/(k+m)$

- 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

[COMPANY NAME]

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE -- COVER PAGE

Benefit Plan(s) \_\_ [Insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only ten standard 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 (20% of Medicare-approved expenses).

**Blood:** First three pints of blood each year.

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

APPENDIX C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the Additional 365 days	All but \$676 All but \$169 a day All but \$338 a day \$0 \$0	\$0 \$169 a day \$338 a day 100% of Medicare Eligible Expenses \$0	\$676 (Part a Deductible) \$0 \$0 \$0 All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but \$84.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$84.50 a day All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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

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

\*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.

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 test, durable medical equipment, First \$100 of Medicare Approved Amounts*	\$0 Generally 80%	\$0 Generally 20%	\$100 (Part B Deductible) \$0
Remainder of Medicare Approved Amounts	\$0	\$0	All Costs
Part B Excess Charges (Above Medicare Approved Amount(s))			
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	100%	\$0	\$0
-- Medically necessary skilled care services and medical supplies			
-- Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$676  All but \$169 a day  All but \$338 a day \$0  \$0	\$676 (Part A Deductible)  \$169 a day  \$338 a day 100% of Medicare Eligible Expenses  \$0	\$0 \$0 \$0 \$0  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day  101st day and after	All approved amounts  All but \$84.50 a day  \$0	\$0  \$0  \$0	\$0  Up to \$84.50 a day  All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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

PLAN B

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

\*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.

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 test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B Deductible) \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$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 -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B Deductible) \$0
---	--------------------	-------------------	---

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$676  All but \$169 a day  All but \$338 a day \$0 \$0	\$676 (Part A Deductible)  \$169 a day  \$338 a day 100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0 \$0 All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day  101st day and after	All approved amounts  All but \$84.50 a day  \$0	\$0  Up to \$84.50 a day  \$0	\$0  \$0  All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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

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

\*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.

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 test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts):	\$0 Generally 80% \$0	\$100 (Part B Deductible) Generally 20% \$0 All Costs	\$0 \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$100 (Part B Deductible) 20%	\$0 \$0 \$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* Remainder of Medicare Approved Amounts	\$0 80%	\$100(Part B Deductible) 20%	\$0 \$0

**OTHER BENEFITS -- NOT COVERED BY MEDICARE**

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

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$676  All but \$169 a day  All but \$338 a day \$0 \$0	\$676 (Part A Deductible)  \$169 a day \$338 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day  101st day and after	All approved amounts  All but \$84.50 a day  \$0	\$0  Up to \$84.50 a day  \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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

PLAN D

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

\*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.

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 test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B Deductible) \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$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* Remainder of Medicare Approved Amounts	\$0 80%	\$0 20%	\$100 (Part B Deductible) \$0

PLAN D

MEDICARE (PARTS A & B) - (CONTINUED)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - (Cont'd) 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	\$0	Actual Charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week	Balance
- Benefit for each visit	\$0		
- Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0		
- 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	\$0	\$0	\$250
First \$250 each Calendar Year	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
Remainder of Charges	\$0		

PLANE

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$676  All but \$169 a day  All but \$338 a day \$0 \$0	\$676 (Part A Deductible)  \$169 a day  \$338 a day 100% of Medicare Eligible Expenses \$0 All Costs	\$0 \$0 \$0 \$0 All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day  101st day and after	All approved amounts  All but \$84.50 a day  \$0	\$0  Up to \$84.50 a day  \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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

PLANE

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

\*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.

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 test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B Deductible) \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$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* Remainder of Medicare Approved Amounts	\$0 80%	\$0 20%	\$100 (Part B Deductible) \$0

**PLAN F**  
**OTHER BENEFITS -- NOT COVERED BY MEDICARE**

<p><b>FOREIGN TRAVEL -- NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA                  First \$250 each Calendar Year                  Remainder of Charges</p>	<p>\$0                  \$0</p>	<p>\$250                  20% and amounts over the \$50,000 lifetime maximum</p>	
<p><b>PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE:</b>                  Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare                  First \$120 each Calendar Year                  Additional charges</p>	<p>\$0                  \$0</p>	<p>\$0                  80% to a lifetime maximum benefit of \$50,000</p>	<p>\$0                  All Costs</p>

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$676  All but \$169 a day  All but \$338 a day \$0 \$0	\$676 (Part A Deductible)  \$169 a day  \$338 a day 100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0 \$0 All Costs
<b>SKILLED NURSING FACILITY CARE:*</b> 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  21st thru 100th day  101st day and after	All approved amounts  All but \$84.50 a day  \$0	\$0  Up to \$84.50 a day  \$0	\$0  \$0  All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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

**PLAN F  
MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR**

\*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.

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 test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$100 (Part B Deductible) Generally 20% \$100	\$0 \$0 \$0
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$100 (Part B Deductible) 20%	\$0 \$0 \$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 -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$100 (Part B Deductible) 20%	\$0 \$0 \$0
--	--------------------	---	-------------------

**OTHER BENEFITS -- NOT COVERED BY MEDICARE**

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

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$676  All but \$169 a day  All but \$338 a day \$0 \$0	\$676 (Part A Deductible)  \$169 a day  \$338 a day 100% of Medicare Eligible Expenses \$0 All Costs	
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day  101st day and after	All approved amounts  All but \$84.50 a day  \$0	\$0  Up to \$84.50 a day  \$0 All Costs	
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0 \$0	
<b>HOSPICE CARE</b> 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 respice care	\$0	Balance

PLAN G

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

\*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.

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 test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% 80%	\$100 (Part B Deductible) \$0 20%
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$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 -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B Deductible) \$0
--	--------------------	-------------------	---

PLAN G

MEDICARE (PARTS A & B) -- (continued)

<p>HOME HEALTH CARE - (Cont'd)                  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</p>	<p>\$0</p>	<p>Actual Charges to \$40 a visit</p>	<p>Balance</p>
<p>- Number of visits covered (must be received within 8 weeks Of last Medicare Approved visit)</p>	<p>\$0</p>	<p>Up to the number of Medicare Approved visits, not to exceed 7 each week</p>	
<p>- Calendar Year Maximum</p>	<p>\$0</p>	<p>\$1,600</p>	

OTHER BENEFITS

<p>FOREIGN TRAVEL -- NOT COVERED BY MEDICARE                  Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA                  First \$250 each Calendar Year                  Remainder of Charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>
---	--------------------	--	---

PLAN II

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$676  All but \$169 a day  All but \$338 a day \$0 \$0	\$676 (Part A Deductible)  \$169 a day  \$338 a day 100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0 \$0 All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day  101st day and after	All approved amounts  All but \$84.50 a day  \$0	\$0  Up to \$84.50 a day  \$0	\$0  \$0  All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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

PLAN II

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

\*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.

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 test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B Deductible) \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$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* Remainder of Medicare Approved Amounts	\$0 80%	\$0 20%	\$100 (Part B Deductible) \$0

PLAN H

MEDICARE (PARTS A & B) -- (continued)

OTHER BENEFITS -- NOT COVERED BY MEDICARE

<p>FOREIGN TRAVEL -- NOT COVERED BY MEDICARE: Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA                      First \$250 each Calendar Year                      Remainder of Charges</p>	<p>\$0                      \$0</p>	<p>\$0                      80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250                      20% and amounts over the \$50,000 lifetime maximum</p>
<p>BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE                      First \$250 each Calendar Year                      Next \$2,500 each Calendar Year                      Over \$2,500 each Calendar Year</p>	<p>\$0                      \$0                      \$0</p>	<p>\$0                      50% - \$1,250 calendar year maximum benefit                      \$0</p>	<p>\$250                      50%                      All Costs</p>

PLAN I

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$676  All but \$169 a day  All but \$338 a day \$0 \$0	\$676 (Part A Deductible)  \$169 a day  \$338 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day  101st day and after	All approved amounts  All but \$84.50 a day  \$0	\$0  Up to \$84.50 a day  \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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

PLAN I

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

\*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.

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 test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% 100%	\$100 (Part B Deductible) \$0 \$0
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$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 -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B Deductible) \$0
--	--------------------	-------------------	---

PLAN I

MEDICARE (PARTS A & B) -- (continued)

<p>HOME HEALTH CARE - (Cont'd)                  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</p>	<p>\$0</p>	<p>Actual Charges to \$40 a visit</p>	<p>Balance</p>
<p>- Number of visits covered (must be received within 8 weeks Of last Medicare Approved visit)</p>	<p>\$0</p>	<p>Up to the number of Medicare Approved visits, not to exceed 7 each week</p>	
<p>- Calendar Year Maximum</p>	<p>\$0</p>	<p>\$1,600</p>	

OTHER BENEFITS

<p>FOREIGN TRAVEL -- NOT COVERED BY MEDICARE: Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA                  First \$250 each Calendar Year                  Remainder of Charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>
<p>BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE                  First \$250 each Calendar Year                  Next \$2,500 each Calendar Year                  Over \$2,500 each Calendar Year</p>	<p>\$0 \$0 \$0</p>	<p>\$0 50% - \$1,250 calendar year maximum benefit \$0</p>	<p>\$250 50% All Costs</p>

PLAN J

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$676  All but \$169 a day  All but \$338 a day \$0 \$0	\$676 (Part A Deductible)  \$169 a day  \$338 a day 100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0 \$0 All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day  101st day and after	All approved amounts  All but \$84.50 a day  \$0	\$0  Up to \$84.50 a day  \$0	\$0  \$0  All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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

PLAN J

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

\*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.

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 test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$100 (Part B Deductible) Generally 20% 100%	\$0 \$0 \$0
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$100 (Part B Deductible) 20%	\$0 \$0 \$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 -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$100 (Part B Deductible) 20%	\$0 \$0 \$0
--	--------------------	---	-------------------

PLAN J  
PARTS A & B (Cont'd)

<p><b>HOME HEALTH CARE - (Cont'd)</b> <b>AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE</b> 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</p>	<p>\$0</p>		<p>Actual Charges to \$40 a visit</p>	<p>Balance</p>
<p>- Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)</p>	<p>\$0</p>		<p>Up to the number of Medicare Approved visits, not to exceed 7 each week</p>	
<p>- Calendar Year Maximum</p>	<p>\$0</p>		<p>\$1,600</p>	

OTHER BENEFITS - NOT COVERED BY MEDICARE

<p><b>FOREIGN TRAVEL -- NOT COVERED BY MEDICARE:</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</p>	<p>\$0</p>		<p>\$0</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>
<p>First \$250 each Calendar Year Remainder of Charges</p>	<p>\$0</p>		<p>\$0</p>	
<p><b>EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE</b></p>	<p>\$0</p>		<p>\$0</p>	<p>\$250 50%</p>
<p>First \$250 each Calendar Year Next \$6,000 each Calendar Year</p>	<p>\$0</p>		<p>\$0</p>	<p>50% - \$3,000 calendar year maximum benefit</p>
<p>Over \$6,000 each Calendar Year</p>	<p>\$0</p>		<p>\$0</p>	<p>All Costs</p>
<p><b>PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE</b></p>	<p>\$0</p>		<p>\$0</p>	<p>\$0</p>
<p>Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare</p>	<p>\$0</p>		<p>\$120</p>	<p>All Costs</p>
<p>First \$120 each Calendar Year Additional charges</p>	<p>\$0</p>		<p>\$0</p>	<p>All Costs</p>

APPENDIX D

FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #

Date of Issuance

Policy and Certificate #	Date of Issuance

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name and Title (Please Type)

\_\_\_\_\_  
Date

APPENDIX E

[COMPANY NAME]  
OUTLINE OF MEDICARE  
SUPPLEMENT COVERAGE  
AND PREMIUM INFORMATION

**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 thirty (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 responses:]

[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 incorporated into this regulation by reference and annexed hereto collectively as Appendix C, "Medicare Supplement Benefits Plans 'A' through 'J', Respectively." An issuer may use additional benefit plan designations on these charts pursuant to Subsection 7.4 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.]

[DRAFTING NOTE: The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate.]

APPENDIX F

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. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

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

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s):

\_\_\_ 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) 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.



KEN HECHLER  
Secretary of State

MARY P. RATLIFF  
Deputy Secretary of State

STEPHEN N. REED  
Deputy Secretary of State

CATHERINE FREROTTE  
Executive Assistant

Telephone: (304) 558-6000  
Corporations: (304) 558-8000  
FAX: (304) 558-0900

WILLIAM H. HARRINGTON  
Chief of Staff

JUDY COOPER  
Director, Administrative Law

PENNEY BARKER  
Supervisor, Corporations

(Plus all the volunteer  
help we can get)

# STATE OF WEST VIRGINIA

## SECRETARY OF STATE

Building 1, Suite 157-K  
1900 Kanawha Blvd., East  
Charleston, WV 25305-0770

May 2, 1996

### NOTICE OF EMERGENCY RULE DECISION BY THE SECRETARY OF STATE

AGENCY: Insurance Commissioner

RULE: Amendments, Series 24 Medicare Supplement Insurance

DATE FILED AS AN EMERGENCY RULE: April 2, 1996

### DECISION NO. 7-96

Following review under WV Code 29A-3-15a, it is the decision of the Secretary of State that the above emergency rule be **approved**. A copy of the complete decision with required findings is available from this office.

KEN HECHLER  
Secretary of State

OFFICE OF WEST VIRGINIA  
SECRETARY OF STATE  
MAY 3 10 48 AM '96  
FILED



KEN HECHLER,  
Secretary of State

MARY P. RATLIFF  
Deputy Secretary of State

STEPHEN N. REED  
Deputy Secretary of State

CATHERINE FREROTTE  
Executive Assistant

Telephone: (304) 558-6000  
Corporations: (304) 558-8000  
FAX: (304) 558-0900

WILLIAM H. HARRINGTON  
Chief of Staff

JUDY COOPER  
Director, Administrative Law

PENNEY BARKER  
Supervisor, Corporations

## STATE OF WEST VIRGINIA

### SECRETARY OF STATE

Building 1, Suite 157-K  
1900 Kanawha Blvd., East  
Charleston, WV 25305-0770

(Plus all the volunteer  
help we can get)

### EMERGENCY RULE DECISION (ERD 7-96)

AGENCY: Insurance Commissioner  
RULE: Amendments, Series 24, Medicare Supplement Insurance  
FILED AS AN EMERGENCY RULE: April 2, 1996

- par. 1 The Insurance Commissioner (Commissioner) has filed the above amendments to an existing rule as an emergency rule.
- par. 2 West Virginia Code 29A-3-15a requires the Secretary of State to review all emergency rules filed after March 8, 1986. This review requires the Secretary of State to determine if the agency filing such emergency rule: 1) has complied with the procedures for adopting an emergency rule; 2) exceeded the scope of its statutory authority in promulgating the emergency rule; or 3) can show that an emergency exists justifying the promulgation of an emergency rule.
- par. 3 Following review, the Secretary of State shall issue a decision as to whether or not such an emergency rule should be disapproved [(29A-3-15a(b))].
- par. 4 (A) Procedural Compliance: WV Code 29A-3-15 permits an agency to adopt, amend or repeal, without hearing, any legislative rule by filing such rule, along with a statement of the circumstances constituting the emergency, with the Secretary of State and forthwith with the Legislative Rule-Making Review Committee (LRMRC).
- par. 5 If an agency has accomplished the above two required filings with the appropriate supporting documents by the time the emergency rule decision is issued or the expiration of the thirty-five day review period, whichever is sooner, the Secretary of State shall rule in favor of procedural compliance.
- par. 6 The Commissioner filed this emergency rule with supporting documents with the Secretary of State April 2, 1996 and with the LRMRC April 2, 1996.

par. 7 It is the determination of the Secretary of State that the Commissioner has complied with the procedural requirements of WV Code §29A-3-15 for adoption of an emergency rule.

par. 8 (B) Statutory Authority -- WV Code §33-28-5b reads in part:

*(1) The commissioner shall issue reasonable rules to establish specific standards for policy provisions of medicare supplement policies. Such standards shall be in addition to and in accordance with the applicable laws of this state and may cover, but shall not be limited to:*

- (A) Terms of renewability*
- (B) Initial and subsequent conditions of eligibility;*
- (C) Nonduplication of coverage;*
- (D) Probationary period;*
- (E) Benefit limitations; exceptions and reductions*
- (F) Elimination period;*
- (G) Requirements for replacement;*
- (H) Recurrent conditions; and*
- (I) Definitions of terms.*

*(2) The commissioner may issue reasonable rules that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair or unfairly discriminatory to any person insured or proposed for coverage under a medicare supplement policy.*

*(3) The commissioner may prescribe by rule a standard form and the contents of an information brochure for persons eligible for medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the information brochure be provided to any prospective insureds eligible for medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for medicare, but in no event later than the time of policy delivery.*

*(4) The commissioner may further promulgate reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies, subscriber contracts or certificates by persons eligible for medicare.*

*(g) Administrative procedures. -- Rules promulgated pursuant to this section shall be subject to the provisions of §29A-1-1 et seq. (the WV Administrative Procedures Act) of this Code.*

par. 9 It is the determination of the Secretary of State that the Commissioner has not exceeded its statutory authority in promulgating this emergency rule.

par. 10 (C) Emergency -- WV Code 29A-3-15(f) defines "emergency" as follows:

*(f) For the purposes of this section, an emergency exists when the promulgation of a rule is necessary for the immediate preservation of the public peace, health, safety or welfare or is necessary to comply with a time limitation established by this code or by a federal statute or regulation or to prevent substantial harm to the public interest.*

par. 11 There are essentially three classes of emergency broadly presented with the above provision: 1) immediate preservation; 2) time limitation; and 3) substantial harm. An agency need only document to the satisfaction of the Secretary of State that there exists a nexus between the proposal and the circumstances creating at least one of the above three emergency categories.

par. 12 The facts and circumstances as presented by the Commissioner are as follows:

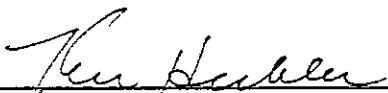
The emergency rule was promulgated in order to comply with Social Security Act Amendments of 1994 (SSAA-94) which established new federal minimum standards for Medicare supplement policies. The State must promulgate this rule by April 28, 1996 to maintain approval as meeting federal minimum standards.

If the State fails to promulgate this rule by April 28, 1996, Medicare Supplement policies may not be sold in West Virginia after this date, unless the Secretary of the U.S. Department of Health and Human Services certifies that the policies meet the new federal standards.

This rule repeals and replaces the Insurance Commissioner's existing Series 24 and adopts the revisions to the 1991 National Association of Insurance Commissioners (NAIC) Model Regulation to implement the requirements of the Medicare Supplement Minimum Standards Model Act. States are required to make the requisite changes to their regulatory programs by April 28, 1996 to maintain approval as meeting minimum federal standards.

par. 13 It is the determination of the Secretary of State that this proposal qualifies under the definition of an emergency as defined in §29A-3-15(f) . . . "federal time limitation."

par. 14 This decision shall be cited as Emergency Rule Decision 7-96 or ERD 7-96 and may be cited as precedent. This decision is available from the Secretary of State and has been filed with the Insurance Commissioner, the Attorney General and the Legislative Rule Making Review Commission.



KEN HECHLER  
Secretary of State

Entered \_\_\_\_\_

OFFICE OF WEST VIRGINIA  
SECRETARY OF STATE

MAY 3 10 48 AM '96

FILED



DEPARTMENT OF HEALTH & HUMAN SERVICES  
BUREAU OF PROGRAM OPERATIONS

**RECEIVED**

DEC 7 1995

Health Care Financing Administration

REC 7

LEGAL DIVISION  
W. VA. INS. DEPT.  
Refer to:

6925 Security Boulevard  
Baltimore, MD 21207

BPO-PR6

NOTE TO: All State Insurance Commissioners

SUBJECT: Procedures and Timeframes for the Review of State Programs under the Medicare Supplement (Medigap) Provisions of the Social Security Act Amendments of 1994 (SSAA-94)

The National Association of Insurance Commissioners (NAIC) completed its revisions to the 1991 NAIC Model Regulation to Implement the Requirements of the Medicare Supplement Minimum Standards Model Act (Model) as required by SSAA-94. States have until April 28, 1996, to make these changes to their regulatory programs to maintain approval as meeting minimum federal standards. If a state fails to make these changes by this date, Medicare supplemental policies may not be sold after this date, unless the Secretary of Health and Human Services certifies that the policies meet the new federal standards. States requiring legislation to make these changes but not having a regular legislative session before this deadline, excluding a session to appropriate funding, may have additional time to implement these changes. Please advise us if you require legislative approval to make these changes and your legislature is not scheduled to meet in a regular session in 1996 in which this legislation can be considered.

As soon as documents are available, we request that States send the finalized statutes and regulations in their entirety, with the SSAA-94 changes highlighted for review. A cover letter should attest that the State has submitted all statutes and regulations and highlighted all pertinent sections. Health Care Financing Administration (HCFA) Regional Offices (RO) will be performing the reviews. Please address your package to the Associate Regional Administrator, Medicare at the RO address identified in enclosure 1.

To help you conform to the revised NAIC Model, we have enclosed a listing of revisions by NAIC section (enclosure 2), copies of the final NAIC Model (enclosure 3) and copies of the NAIC strike-through Model (enclosure 4).

Several areas of changes to the 1991 Model are worthy of special note. Briefly, these are:

- o Section 4 (Definitions) - After December 31, 1995, new enrollments in Health Care Prepayment Plans (HCPPs) under Section 1833 of the Social Security Act will no

longer be exempt from the definition of a "Medicare Supplement Policy" unless these plans are employer or union based. Thereafter, non-exempt HCPPs are to be held to all Medicare supplement requirements, including standardization, loss ratios and Medicare SELECT. SELECT provisions apply because HCPPs impose network restrictions. You should be aware that on July 7, 1995, the President signed legislation extending the Medicare SELECT program for three years, and making it available to all States that wish to participate. States that were not formerly included in the Medicare SELECT demonstration, and that now wish to permit HCPPs or other entities to offer Medicare SELECT policies, must adopt regulatory provisions equivalent to or more stringent than Section 10 of the NAIC Model Regulation.

- o Section 8A(7)(a) (Benefit Standards for Policies or Certificates Issued or Delivered on or After (insert effective date adopted by state))- The language dealing with refund of premiums for retroactively determined periods of Medicaid eligibility has been struck. States are cautioned to make this change to ensure that refunds of premiums will not adversely affect beneficiaries' retroactive Medicaid eligibility. This reading of the law is in keeping with the approach taken in the Medigap Bulletin Series (Number One)(Transmittal No. 94-1), questions 8-14, especially question 13 (enclosure 5).
- o Section 11 (Open Enrollment) - Effective January 1, 1995, a 6-month open enrollment period is extended at age 65 to all those individuals who are both 65 and enrolled in Medicare Part B, regardless of previous enrollment. This allows disabled and End Stage Renal Disease beneficiaries to have a 6-month open enrollment period at age 65. If a State has more liberal open enrollment provisions before age 65, it must still provide for this expansion of open enrollment at 65.
- o Section 13 (Loss Ratio Standards and Refund or Credit of Premium) - The revised NAIC Model methodology of Section 13(A)(4) assumes that premium calculations for pre-standardized policies were based on a lifetime loss ratio requirement of 60%. Other than in the area of the standardized benefit packages, however, States have always had the option of adopting standards more stringent than the Model. States that have required all pre-standardized policies to meet at least 65%/75% loss ratios prior to the passage of SSAA-94 do not need to change their methodologies by adopting the 3 step

process of Section 13(A)(4). For purpose of documentation, however, please submit an explanation that includes the loss ratios previously used during the lifetime of the pre-standardized policies and a request to continue your present methodology with your revised laws/regulations.

In addition, any States that wish to use an aggregate methodology for reviewing premium rates may do so by including the methodology in their laws/regulations when they are submitted for review to HCFA.

A new subsection requires that pre-standardized policies pay either a refund or a credit, but only on claims experience after the State's revised regulation is in force.

- o Section 15 (Permitted Compensation Arrangements) - This section removes the trigger for paying first year commission based on benefits in a replacement policy which are clearly and substantially greater than in a replaced policy. Section 19 requires that all replacement policies, even though benefits are upgraded, earn the agent no more than the second year commission rate. Section 22 which also deals with upgraded benefits is unaffected by this. Pre-existing conditions provisions may still be applied to upgraded benefits, if State regulation permits.
- o Section 16 (Required Disclosure Provisions) - General Rules (A)(6)(a) removes "other than incidentally" and "by reason of age" qualifiers to hospital or medical expense indemnity products.

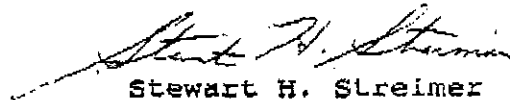
Notice for non-Medigap products (D)(1) removes exceptions for basic, catastrophic, major medical, single premium nonrenewable policies and "by reason of age". Now, such products must disclose the extent to which they duplicate Medicare through the use of the appropriate statement. Refer to Appendix C of the revised Model Regulation.

- o Section 17 (Requirements for Application Forms and Replacement Coverage) - Extensive wording changes in both the Statements and Questions Sections in A have been made to provide sufficient information to follow the SSAA-94 revisions to the anti-duplication provisions of OBRA 90. See Medigap Bulletin Series (Number Four) (Transmittal No. 95-1), questions 2 and 3 (enclosure 6).

- o Section 19 (Standards for Marketing) - Removes the requirement of developing a mechanism for paying higher first year commissions referenced in Section 15.

Our ROs are looking forward to working with you in the implementation of the revised standards. Although we are conducting a streamlined review of State programs by requesting finalized documents which are highlighted to reflect your revisions, please alert the RO contact if you have any unusual modifications in process which might require HCFA approval. If you or your staff have questions relating to the review process described in this letter, please contact Gertrude Saunders (410-786-5888) or Dale Jones (410-786-6405) of my staff. After December 18, questions concerning Medigap State regulation reviews should be directed to the RO contact identified in enclosure 1. It would be very helpful to have your staff inform the RO contact of the person in your Department who will be working on the latest revisions and when we might anticipate receiving your final regulation for review.

Sincerely,



Stewart H. Streimer  
Director  
Office of Program Requirements

6 Enclosures

cc:  
Insurance Department Contact Person  
NAIC  
HCFA, Associate Regional Administrators, Medicare