

WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #3

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OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

AGENCY: Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY WV Code §§33-28-5b, 33-2-10, 33-11-7, 33-16-3d,
33-24-4, 33-25-A, and 33-25-A

AMENDMENT TO AN EXISTING RULE: YES NO

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: 24

TITLE OF RULE BEING PROPOSED: Permanent Regulations on Medicare
Supplement Insurance

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.



Hanley C. Clark
Insurance Commissioner

\$13.00

STATE OF WEST VIRGINIA



GASTON CAPERTON
GOVERNOR

HANLEY C. CLARK
INSURANCE COMMISSIONER

OFFICES OF THE
INSURANCE COMMISSIONER
2019 WASHINGTON STREET, EAST
CHARLESTON, WEST VIRGINIA 25305

FILED
JAN 10 1991
LEGAL DIVISION
304) 348-0401
FACSIMILE
(304) 348-0412

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 33, Series 24, relating to Permanent Medicare Supplement Regulations.

Signed this 9th day of August, 1990.

Charles O. Lorensen
Secretary of Tax and Revenue

RECEIVED
JAN 18 1991
Legislative Rule Making
Review Committee



STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

Legal Division

GASTON CAPERTON
Governor

HANLEY C. CLARK
Insurance Commissioner

July 17, 1991

HAND DELIVERED

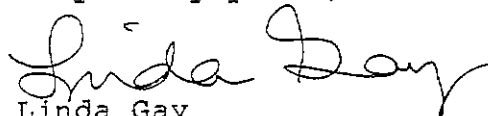
Ms. Judy Cooper, Director
Administrative Law Division
Office of Secretary of State
State Capitol
Charleston, WV 25305

FILED
1991 JUL 17 PM 4:55
OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

Dear Ms. Cooper:

Enclosed please find for filing "Notice of Agency Approval of a Proposed Rule and Filing with the Legislative Rule-Making Review Committee," "Description of Rule," "Legislative Rule-Making Review Committee Questionnaire" and a copy of the proposed rule "Permanent Regulations on Medicare Supplement Insurance" for Series 24, Title 114.

Very truly yours,


Linda Gay
Associate General Counsel

LG/cjs
Enclosures

FISCAL NOTE FOR PROPOSED RULES

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JAN 18 1991

Rule Title: Permanent Regulations to Implement Changes in Medicare Supplement Insurance to Conform to Medicare Catastrophic Coverage Repeal Act of 1989

Type of Rule: Legislative Interpretive Procedural

Agency: Insurance Commissioner Address: 2019 Washington Street, East,
Charleston, West Virginia 25305

1. Effect of Proposed Rule	ANNUAL		FISCAL YEAR		
	Increase	Decrease	Current	Next	Thereafter
Estimated Total Cost.		NONE			

Personal Services

Current Expense

NONE

Repairs & Alterations

Equipment

Other

2. Explanation of above estimates:

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

3. Objectives of these rules:

To adopt current minimum federal standards for Medicare supplement insurance policies. These rules include all of the consumer protection amendments contained in the December 7, 1989 National Association of Insurance Commissioners Model Regulation for Medicare supplement policies.

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Legislative Rule Making
Review Committee

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 most of the standards set by this rule for Medicare supplement insurance.

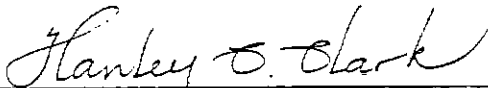
Medicare recipients will benefit economically by this rule's provisions on premium and benefit levels for Medicare supplement insurance policies.

C. Economic Impact on Citizens/Public at Large.

NONE

Date: January 18, 1991

Signature of Agency Head or Authorized Representative



Hanley C. Clark
Insurance Commissioner

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE
FROM: OFFICE OF THE INSURANCE COMMISSIONER
DATE: July 17, 1991
LEGISLATIVE RULE TITLE: Permanent Regulations on Medicare
Supplement Insurance (Series 24)

DESCRIPTION OF RULE

The Insurance Commissioner regulates insurance policies sold to supplement benefits provided under the federal Medicare program. The benefit and premium levels of Medicare supplement insurance policies are therefore contingent upon and coordinated with benefits provided by the Medicare program.

The proposed rule meets current federal requirements for Medicare supplement policies or certificates, pursuant to amendments to the federal Social Security Act that were contained in the Medicare Catastrophic Coverage Repeal Act (MCCRA) of 1989. Furthermore, by incorporating language contained in the National Association of Insurance Commissioners (NAIC's) model rule on Medicare supplement insurance (revised as of July 12, 1991), the West Virginia Insurance Commissioner's proposed rule is also designed to satisfy the requirements established by the federal Omnibus Budget Reconciliation Act of 1990 (OBRA '90). Each state will be required to have regulations in effect by June 1992 that satisfy these OBRA '90 standards.

DATE: July 17, 1991
TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE
FROM: OFFICE OF THE INSURANCE COMMISSIONER
LEGISLATIVE RULE TITLE: Permanent Regulations on Medicare
Supplement Insurance

(Series 24)

1. Authorizing statute(s) citation West Virginia Code
§§ 33-28-5b, 33-2-10, 33-11-7, 33-16-3d, 33-24-4, 33-25A-8
and 33-25A-20

2. a. Date filed in State Register with Notice of Hearing:
January 18, 1991

- b. What other notice, including advertising, did you give
of the hearing?
NONE

- c. Date of hearing(s): The public comment period ended
on February 20, 1991 at 4:30 p.m.

- d. Attach list of persons who appeared at hearing,
comments received, amendments, reasons for amendments.
Attached X No comments received

- e. Date you filed in State Register the agency approved
proposed Legislative Rule following public hearing:
(be exact)
July 17, 1991

- f. Name and phone number of agency person to contact for
additional information:
B. Keith Huffman
General Counsel
(304) 348-0401

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

Not applicable

b. Date of hearing: Not applicable

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

Not applicable

d. Attach findings and determinations and reasons:

Attached Not applicable

EMERGENCY

WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

CHAPTER 33-28
SERIES 24

PERMANENT REGULATIONS TO IMPLEMENT CHANGES ON
IN MEDICARE SUPPLEMENT INSURANCE TO CONFORM TO
MEDICARE-CATASTROPHIC-COVERAGE-REPEAL-ACT-OF-1989

Section 1. General

Section 2. Definitions

Section 3. Policy Definitions and Terms

Section 4. Prohibited Policy Provisions

~~Section 5. Benefit Conversion Requirements During Transition~~

Section 6. 5. Minimum Benefit Standards for Policies or
Certificates Issued for Delivery Prior to
[insert effective date adopted by state]

Section 6. Benefit Standards for Policies or Certificates
Issued or Delivered on or After [insert effective
date adopted by state]

Section 7. Standard Medicare Supplement Benefit Plans

Section 8. Medicare Select Policies and Certificates

Section 9. Open Enrollment

Section 7. 10. Standards for Claims Payment

Section 8. 11. Loss Ratio Standards and Refund or Credit of
Premium

~~Section 9. Filing Requirements for Out-of-State Group
Policies~~

Section 12. Filing and Approval of Policies and Certificates and
Premium Rates

Section 10. 13. Permitted Compensation Arrangements

Section 11. 14. Required Disclosure Provisions

Section 12. 15. Requirements for Application Forms and
Replacement Coverage

- Section ~~13~~ 16. Filing Requirements for Advertising
- Section ~~14~~ 17. Standards for Marketing
- Section ~~15~~ 18. Appropriateness of Recommended Purchase and Excessive Insurance
- Section ~~16~~ 19. Reporting of Multiple Policies
- Section ~~17~~ 20. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates

Section ~~18~~ 21. Separability

Appendix-----Notice-Form

Appendix A Reporting Form for Calculation of Loss Ratios

Appendix B Outline of Medicare Supplement Coverage--Cover Page

Appendix C Charts Describing Medicare Supplement Benefit Plans "A" through "J", Respectively (22 pages)

Appendix D Form for Reporting Duplicate Policies

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SECRETARY OF STATE

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WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

CHAPTER 33-28
SERIES 24

PERMANENT REGULATIONS TO IMPLEMENT CHANGES ON
IN MEDICARE SUPPLEMENT INSURANCE TO CONFORM TO
MEDICARE-CATASTROPHIC-COVERAGE-REPEAL-ACT-OF-1989

Section 1. General

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

1.2 Authority - West Virginia Code §33-28-5b, §33-2-10, §33-11-7, §33-16-3d, §33-24-4, §33-25A-8 and §33-25A-20.

1.3 Filing Date -

1.4 Effective Date -

1.5 Scope and Applicability - This regulation shall supercede the previous Series 24 of the Rules and Regulations of the West Virginia Insurance Commissioner titled "Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Repeal of Medicare Catastrophic Coverage Act," filing and effective date December 29, 1989, and such other regulations of the commissioner to the extent that they are inconsistent with the provisions hereof. Except as otherwise specifically provided, this regulation shall apply to:

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WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

CHAPTER 33-28
SERIES 24

PERMANENT REGULATIONS ~~TO IMPLEMENT CHANGES ON~~
~~IN MEDICARE SUPPLEMENT INSURANCE TO CONFORM TO~~
~~MEDICARE-CATASTROPHIC-COVERAGE-REPEAL-ACT-OF-1989~~

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1.2 Authority - West Virginia Code §33-28-5b, §33-2-10, ~~§33-11-7~~, §33-16-3d, §33-24-4, ~~§33-25A-8~~ and §33-25A-20.

1.3 Filing Date -

1.4 Effective Date -

1.5 Scope and Applicability - This regulation shall supercede the previous Series 24 of the Rules and Regulations of the West Virginia Insurance Commissioner titled "Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Repeal of Medicare Catastrophic Coverage Act," filing and effective date December 29, 1989, and such other regulations of the commissioner to the extent that they are inconsistent with the provisions hereof. Except as otherwise specifically provided, this regulation shall apply to:

Insurance Commissioner
Leg. Rule 33-22
Series 24
EMERGENCY

(A) All Medicare supplement policies ~~and-subscriber contracts~~ 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 ~~er-subscriber-contracts~~, 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.

Section 2. Definitions

As used in this legislative rule:

2.1 "Applicant" means:

(A) in the case of an individual Medicare supplement policy ~~er-subscriber-contract~~, the person who seeks to contract for insurance benefits, and

(B) in the case of a group Medicare supplement policy ~~er-subscriber-contract~~, the proposed certificateholder.

2.2 "Certificate" means any certificate delivered or issued for delivery in this State under a group Medicare supplement policy, ~~which-certificate-has-been-delivered-or-issued for-delivery-in-this-State.~~

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

~~2.3~~ 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.

Insurance Commissioner
Leg. Rule 33-22
Series 24
EMERGENCY

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 or Section 1833 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project authorized pursuant to amendments to the federal Social Security Act, 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 by-reason-of-age.

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

Section 3. Policy Definitions and Terms

3.1 No insurance policy or subscriber-contract certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless such policy or subscriber-contract certificate contains definitions or terms which conform to the requirements of this 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 as more restrictively than as that defined in the Medicare program.

3.4 "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall not be defined in relation to its status, facilities and available services, more restrictively than as defined in the Medicare program.

~~(A) -- A definition of such home or facility shall not be more restrictive than one requiring that it:~~

~~(1) be operated pursuant to law;~~

~~(2) be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;~~

~~(3) be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;~~

~~(4) provide continuous twenty-four (24) hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and~~

~~(5) maintain a daily medical record of each patient.~~

~~(B) -- The definition of such home or facility may provide that such term not be inclusive of:~~

~~(1) any home, facility or part thereof used primarily for rest;~~

~~(2) a home or facility for the aged or for the care of drug addicts or alcoholics; or~~

~~(3) a home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.~~

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:

Insurance Commissioner
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Series 24
EMERGENCY

- (A) home office and overhead costs;
- (B) advertising costs;
- (C) commissions and other acquisition costs;
- (D) taxes;
- (E) capital costs;
- (F) administrative costs; ~~or~~ and
- (G) claims processing costs.

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

~~(A) -- The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:~~

~~(1) be an institution operated pursuant to law, and;~~

~~(2) be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities (except an accredited institution for the treatment of chronic diseases) for the medical care and treatment of sick or injured persons on an inpatient basis for which charge is made; and~~

~~(3) provide twenty four (24) hour nursing service by or under the supervision of registered graduate professional nurses (R.N.s).~~

~~(B) -- The definition of the term "hospital" may state that such term shall not be inclusive of:~~

~~(1) convalescent homes, convalescent, rest or nursing facilities; or~~

~~(2) facilities primarily affording custodial, educational or rehabilitary care; or~~

~~(3) - facilities for the aged, drug addicts or
alcoholics.~~

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 health-care expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare. ~~Payment of benefits by insurers for Medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity, as are applicable to Medicare claims.~~

~~3.9 --- "Mental or Nervous Disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.~~

~~3.10 -- "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse," "trained nurse," or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualified under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the State.~~

~~3.11 3.9 "Physician" may shall not be defined by including words such more restrictively than as defined in the Medicare program, as "duly qualified physician" or "duly licensed physician." The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.~~

~~3.12 3.10 "Sickness" shall not be defined to be more restrictive than the following:~~

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"Sickness" means sickness illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

Section 4. Prohibited Policy Provisions

~~4.1 -- No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy if such policy or subscriber contract limits or excludes coverage by type of illness, accident, treatment or medical condition, except as follows:~~

~~(A) -- foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;~~

~~(B) -- mental or emotional disorders, alcoholism and drug addiction;~~

~~(C) -- illness, treatment or medical condition arising out of:~~

~~(1) war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or units auxiliary thereto;~~

~~(2) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;~~

~~(3) aviation;~~

~~(D) -- cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;~~

~~(E) -- care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effect thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column;~~

Insurance Commissioner
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~~(F) -- benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;~~

~~(G) -- dental care or treatment;~~

~~(H) -- eyeglasses, hearing aids and examination for the prescription or fitting thereof;~~

~~(I) -- rest cures, custodial care, transportation and routine physical examinations;~~

~~(J) -- territorial limitations outside the United States;~~

~~provided, however, supplemental policies may not contain, when issued, limitations or exclusions of the type enumerated in Subsections (A), (E), (F), or (J) above that are more restrictive than those of Medicare. Medicare supplement policies may exclude coverage for any expense to the extent of any benefit available to the insured under Medicare.~~

4.1 Except for permitted preexisting condition clauses as described in Section 5.2(A) and Section 6.2(A) 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 -- The terms "Medicare Supplement," "Medigap" and words of similar import shall not be used unless the policy is issued in compliance with this regulation.~~

~~4.4~~ 4.3 No Medicare supplement insurance policy, contract or certificate in force in the State shall contain benefits which duplicate benefits provided by Medicare.

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~~Section 5. Benefit Conversion Requirements During Transition~~

~~5.1 Effective January 1, 1990, no Medicare supplement insurance policy, contract or certificate in force in this State shall contain benefits which duplicate benefits provided by Medicare.~~

~~5.2 Benefits eliminated by operation of the Medicare Catastrophic Coverage Act of 1988 transition provisions shall be restored.~~

~~5.3 For Medicare supplement policies subject to the minimum standards adopted by the states pursuant to Medicare Catastrophic Coverage Act of 1988, the minimum benefits shall be:~~

~~(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 A;~~

~~(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 [\$75];~~

~~(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.~~

Section 6 5. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to [insert effective date adopted by State]

~~6.1~~ 5.1 No insurance policy or subscriber-contract certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate ~~which does not meet~~ unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

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

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

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

(3) (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.

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

(a) (1) provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(b) (2) be cancelled or nonrenewed by the insurer solely on the grounds of deterioration of health.

(5)-(a) (E) (1) Except as authorized by the commissioner, an ~~insurer~~ issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(b) (2) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph 5(d) Section 5.2(E)(4), the ~~insurer~~ issuer shall offer certificateholders an individual Medicare supplement policy. The ~~insurer~~ issuer shall offer the certificateholder at least the following choices:

(1) (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 which provides for continuation of the benefits contained in the group policy; and

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

(e)-(3) If membership in a group is terminated, the ~~insurer~~ issuer shall:

(1) (a) offer the certificateholder such conversion opportunities as are described in Paragraph 5(b) Section 5.2(E)(2) ; or

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

(d) (4) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding ~~insurer~~ issuer 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.

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

(B) 5.3 Minimum Benefit Standards.

(1) (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;

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

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

(4) (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;

(5) (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;

(6) (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 [\$75 \$100];

(7) (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.

~~(C) -- Medicare-Eligible Expenses.~~

~~Medicare-eligible expenses shall mean health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable by Medicare. -- Payment of benefits by insurers for Medicare-eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity, as are applicable to Medicare claims.~~

Section 6. Benefit Standards for Policies or Certificates Issued or Delivered on or After [insert effective date adopted by state]

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

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

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

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

(3) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 6.2(E)(5), 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.

(4) 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 Section 6.2(E)(3), or

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

(5) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding issuer shall offer coverage

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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) (1) 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 such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance. Upon receipt of timely notice, the issuer shall return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

(2) 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 certificate holder 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.

(3) 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 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 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:

(1) An annual clinical preventive medical history and physical examination that may include tests and services from subsection (2) below and patient education to address preventive health care measures.

(2) 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;

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

(f) Thyroid function test;

(g) Diabetes screening.

(3) Influenza vaccine administered at any appropriate time during the year and Tetanus and Diphtheria booster (every ten (10) years).

(4) 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.

(1) 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 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.

(2) Coverage Requirements and Limitations

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

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

(c) Coverage is limited to:

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

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

(iii) One thousand six hundred dollars (\$1,600) per calendar year.

(iv) Seven (7) visits in any one week.

(v) Care furnished on a visiting basis in the insured's home.

(vi) Services provided by a care provider as defined in this section.

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

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

(3) Coverage is excluded for:

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

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

(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.

Section 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 Section 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 Section 6.4(K) and in Section 8 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 Sections 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 Section 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 Benefit Plans, as defined in Section 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 Section 6.4(A).

(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 Sections 6.4(A), (B), (C) and (H) 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 Sections 6.4(A), (B), (H) and (J) 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 Sections 6.4(A), (B), (H) and (I) 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 Sections 6.4(A), (B), (C), (E) and (H) 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 Sections 6.4(A), (B), (D), (H) and (J) respectively.

(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 Sections 6.4(A), (B), (F) and (H) 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 Sections 6.4(A), (B), (E), (F), (H), and (J) 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 Sections 6.4(A), (B), (C), (E), (G), (H), (I) and (J) respectively.

Section 8. Medicare Select Policies and Certificates

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

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

8.2 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 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.

8.3 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.

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

8.5 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:

(1) 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 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.

(2) 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.

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

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

(5) 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:

(1) The formal organizational structure;

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

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

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

(F) Copies of the written information proposed to be used by the issuer to comply with Section 8.9.

(G) Any other information requested by the commissioner.

8.6 (A) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list

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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 shall be filed with the commissioner at least quarterly.

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

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

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

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

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

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

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

(2) Other Medicare Select policies or certificates.

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

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

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(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.

8.10 Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Section 8.9 of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

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

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

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

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

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

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

(F) The issuer shall report no later than each March 31 to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and

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shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

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

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

(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.

8.14 Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this 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 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

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

Section 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 where an application for such policy or certificate is submitted during the six (6) month period beginning with the first month in which an individual (who is 65 years of age or older) first 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 (A) The issuer of a Medicare supplement policy or certificate shall not deny or condition the issuance or effectiveness of a Medicare supplement policy or certificate, or discriminate in the pricing of the policy or certificate, because of health status, claims experience, receipt of health care, or medical condition for which an application is submitted during the six (6) month period beginning with the first month in which an individual (who is 65 years of age or older) first enrolled for benefits under Part B.

(B) Section 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 it became effective.

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Section 7- 10. Standards for Claims Payment

7-1 10.1 Every-entity-providing An issuer Medicare supplement policies-or-contracts shall comply with all-provisions of-Section 4081-of-the-Omnibus-Budget Reconciliation-Act--of-1987 (P.L. 100-203)- section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

(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.

7-2 10.2 Compliance with the requirements set forth in Subsection 7-1 Section 10.1 above-must shall be certified on the Medicare supplement insurance experience reporting form.

Section 8- 11. Loss Ratio Standards and Refund or Credit of Premium

8-1 11.1 Loss Ratio Standards--A Medicare supplement policies-shall-return-to policyholders-in-the-form-of-aggregate benefits-under-the-policy; policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, on-the

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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, 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 80 75 percent of the aggregate amount of premiums earned in the case of group policies, and or

(B) At least 70 65 percent of the aggregate amount of premiums earned in the case of individual policies.

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.

(C) All filings of rates and rating schedules shall demonstrate that actual-and expected losses 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.

(D) For purposes of applying Section 11.1(A) and Section 12.3(C) 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.

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 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, 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

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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) 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.

(E) (A) Every entity providing 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 number of years of policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. demonstrating that it is in compliance with the foregoing applicable loss ratio standards and that the period for which the policy is rated is reasonable in accordance with accepted actuarial principles and experience. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

~~-----For the purposes of this section, policy forms shall be deemed to comply with the loss ratio standards if:--(i) for the most recent year, the ratio of the incurred losses to earned premiums for policies or certificates which have been in force for three years or more is greater than or equal to the applicable percentages contained in this section; and (ii) the expected losses in relation to premiums over the entire period for which the policy is rated comply with the requirements of--~~

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~~this section. -- An expected third year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.~~

(B) 11.4 As soon as practicable, but prior to the effective date of enhancements in Medicare benefit-changes benefits, every insurer, health-care-service-plan-or-other-entity issuer providing of Medicare supplement-insurance-or contracts-policies or certificates in this State shall file with the commissioner, in accordance with the applicable filing procedures of this State:

~~(1)~~-(a) (A) (1) Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the current premium for the applicable policies or contracts. Such supporting documents as necessary to justify the adjustment shall accompany the filing, and

(b) (2) Every insurer, health-care-service-plan-or-other-entity issuer An issuer Medicare supplement-insurance-or-benefits-to-a-resident-of-this-State-pursuant-to this-regulation shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or contract 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 insurer, health-care-service-plan-or-other-entity issuer for such Medicare supplement insurance policies or contracts 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.

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

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

11.5 Public Hearings.

The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of these "Permanent Regulations on Medicare Supplement Insurance" if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner consistent with the provisions of West Virginia 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.

~~Section 9:-- Filing Requirements for Out-of-State Group Policies~~

~~9:1-- Every insurer providing group Medicare supplement insurance benefits to a resident of this State pursuant to this regulation shall file a copy of the master policy and any certificate used in this State in accordance with the filing requirements and procedures applicable to group Medicare supplement policies issued in this State; provided, however, that no insurer shall be required to make a filing earlier than thirty (30) days after insurance was provided to a resident of this State under a master policy issued for delivery outside this State.~~

Section 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 (A) Except as provided in paragraph (B) of this subsection, an issuer shall not file for approval more than one

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form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(B) An issuer may offer, with the approval of the 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:

- (1) The inclusion of new or innovative benefits;
- (2) The addition of either direct response or agent marketing methods;
- (3) The addition of either guaranteed issue or underwritten coverage;
- (4) The offering of coverage to individuals eligible for Medicare by reason of disability.

(C) 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.

12.4 (A) Except as provided in paragraph (A)(1) 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 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.

(1) 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.

(2) An issuer that discontinues the availability of a policy form or certificate form pursuant to Section 12.4(A)(1) 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.

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(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 Section 12.4(A) unless the issuer complies with the following requirements:

(1) 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 resultant rates.

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

12.5 (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.

Section 10-13. Permitted Compensation Arrangements

10-1 13.1 An insurer issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no 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.

10-2 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

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other than a maximum five percent (5%) maintenance or service fee per policy year or period.

~~10-3~~ 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 ~~insurer~~ issuer on renewal policies or certificates if an existing policy or certificate is replaced unless benefits of the new policy or certificate are clearly and substantially greater than the benefits under the replaced policy.

~~10-4~~ 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.

Section ~~11-~~ 14. Required Disclosure Provisions

~~11-1~~ 14.1 General Rules.

(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 ~~insurer~~ 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 must shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement insurance 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) A Medicare supplement policies or certificates which shall not ~~prevides~~ provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall ~~include-a-definition-of-such-terms-and-an-explanation-of-such-terms-in-its-accompanying-outline~~ of coverage.

(D) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations must 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 ~~or~~ 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.

(F) ~~Insurers-issuing~~ Issuers of accident and sickness policies, ~~or certificates or subscriber-contracts~~ which provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to a person(s) eligible for Medicare by reason of age shall provide to ~~all~~ such applicants a Medicare Supplement Buyer's Guide in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12 point type. Delivery of the Buyer's Guide shall be made whether or not such policies, ~~or certificates or subscriber-contracts~~ are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response ~~insurers issuers~~, delivery of the Buyer's Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Buyer's Guide shall be obtained by the ~~insurer issuer~~. Direct response ~~insurers issuers~~ shall deliver the Buyer's Guide to the applicant upon request but not later than at the time the policy is delivered.

~~11-2~~ 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, ~~every insurer, health-care-service-plan-or-other~~

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~~entity an issuer providing Medicare supplement insurance or benefits to a resident of this State shall notify its policyholders, contract-holders and certificateholders of modifications it has made to Medicare supplement insurance policies or contracts~~ certificates in a format acceptable to the commissioner ~~or in the format prescribed in the Appendix if no other format is prescribed by the commissioner.~~ Such notice shall:

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

(2) Inform each ~~covered person~~ 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.

~~11-9~~ 14.3 Outline of Coverage Requirements for Medicare Supplement Policies.

(A) ~~Insurers-issuing~~ Issuers Medicare supplement ~~policies or certificates for delivery in this State~~ shall provide an outline of coverage to all applicants at the time application is made 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 must 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 Paragraphs ~~(1) and (2)~~ shall be in the form

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prescribed-below: 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 below. 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 on pages 41 and 42 of this regulation. Examples of charts displaying the features of each Medicare supplement benefit plan offered by the issuer are contained in Appendix C, consisting of 22 pages, which is annexed hereto and incorporated herein by reference.

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[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]

~~1.-----Read your Policy Carefully----- This outline of coverage provides a very-----
-----brief description of the important features of your policy.----- This is not-----
-----the insurance contract and only the actual policy provisions will-----
-----control.----- The policy itself sets forth in detail the rights and-----
-----obligations of both you and your insurance company.----- It is, therefore,-----
-----important that you READ YOUR POLICY CAREFULLY!-----~~

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

RIGHT TO RETURN POLICY [Boldface Type]

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

~~2.-----Medicare Supplement Coverage----- Policies of this category are designed to-----
-----supplement Medicare by covering some hospital, medical and surgical-----
-----services which are partially covered by Medicare.----- Coverage is provided-----
-----for hospital inpatient charges and some physician charges,----- subject to-----
-----any deductibles and copayment provisions which may be in addition to-----
-----those provided by Medicare,----- and subject to other limitations which may-----
-----be set forth in the policy.----- The policy does not provide benefits for-----
-----custodial care such as help in walking, getting in and out of bed,-----
-----eating, dressing, bathing and taking medicine (delete if such coverage-----
-----is provided).-----~~

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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.

3- (a) [for agents:]

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

(b) [for direct responses:]

[insert company's name] is not connected with Medicare.

~~4- [A brief summary of the major medical benefit gaps in Medicare Parts A & B with a parallel description of supplemental benefits, including dollar amounts (and indexed copayments or deductibles, as appropriate), provided by the Medicare supplement coverage in the following order:]~~

<u>DESCRIPTION</u>	<u>THIS POLICY PAYS**</u>	<u>YOU PAY</u>
I. Minimum Standards		
SERVICE		
<u>PART A</u>		
INPATIENT HOSPITAL SERVICES:		
Semi-Private Room & Board		
Miscellaneous Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room		
BLOOD		
<u>PART B</u>		
MEDICAL EXPENSE:		
Services of a Physician/ Outpatient Services		

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THIS POLICY
PAYS**

YOU PAY

DESCRIPTION

Medical Supplies other than
Prescribed Drugs

BLOOD

MISCELLANEOUS

Immunosuppressive Drugs

II. Additional Benefits

PART A

Part A Deductible

Private Rooms

In-Hospital Private Nurses

Skilled Nursing Facility Care

PARTS A & B

Home Health Services

PART B

Part B Deductible

Medical Charges in Excess of
Medicare Allowable Expenses
(Percentage Paid)

OUT-OF-POCKET MAXIMUM

PRESCRIPTION DRUGS

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THIS POLICY
PAYS**

YOU PAY

DESCRIPTION

MISCELLANEOUS

Respite Care Benefits

Expenses Incurred in
Foreign Country

Other:

TOTAL PREMIUM

\$ _____

IN ADDITION TO THIS OUTLINE OF COVERAGE, [INSURANCE COMPANY NAME] WILL SEND AN ANNUAL NOTICE TO YOU 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES WHICH WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

**If this policy does not provide coverage for a benefit listed above, the insurer must state "no coverage" beside that benefit in the first column.

5. [The following chart shall accompany the outline of coverage:]

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[COMPANY NAME]
 NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT COVERAGE - 1990

THE FOLLOWING CHART BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ THIS CAREFULLY!

[A BRIEF DESCRIPTION OF THE REVISIONS TO MEDICARE PARTS A & B WITH A PARALLEL DESCRIPTION OF SUPPLEMENTAL BENEFITS WITH SUBSEQUENT CHANGES, INCLUDING DOLLAR AMOUNTS, PROVIDED BY THE MEDICARE SUPPLEMENT COVERAGE IN SUBSTANTIALLY THE FOLLOWING FORMAT.]

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	In 1989 Medicare Pays Per Calendar Year	Effective January 1, 1990, Medicare Will Pay	In 1989 Your Coverage Pays	Effective January 1, 1990, Your Coverage Will Pay
MEDICARE PART A SERVICES AND SUPPLIES				
Inpatient Hospital Services	Unlimited number of hospital days after \$560 deductible	All but \$592 for first 60 days/benefit period		
Semi-Private Room & Board		All but \$148 a day for 61st-90th days/benefit period		
Misc. Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room		All but \$296 a day for 91st-150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)		
BLOOD	Pays all costs except payment of deductible (equal to costs for first 3 pints) each calendar year. Part A blood deductible reduced to the extent paid under Part B	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in each calendar year		

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SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	<u>In 1989 Medicare Pays Per Calendar Year</u>	<u>Effective January 1, 1990, Medicare Will Pay</u>	<u>In 1989 Your Coverage Pays</u>	<u>Effective January 1, 1990, Your Coverage Will Pay</u>
SKILLED NURSING FACILITY CARE	There is no prior confinement requirement for this benefit	100% of costs for first 20 days (after a 3 day prior hospital confinement)/ benefit period		
	First 8 days - All but \$25.50 a day	All but \$74.00 a day for 21st-100th days/benefit period		
	9th through 150th day - 100% of costs	Beyond 100 days - Nothing/benefit period		
	Beyond 150 days - Nothing			
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after \$75 deductible)	80% of allowable charges (after \$75 deductible/ calendar year)		
PRESCRIPTION DRUGS	Inpatient prescription drugs. 80% of allowable charges for immuno- suppressive drugs during the first year following a covered trans- plant (after \$75 deductible/ calendar year)	Inpatient prescription drugs. 80% of allowable charges for immunosup- pressive drugs during the first year following a covered transplant (after \$75 deductible/calendar year)		

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SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	In 1989 Medicare Pays Per Calendar Year	Effective January 1, 1990, Medicare Will Pay	In 1989 Your Coverage Pays	Effective January 1, 1990, Your Coverage Will Pay

BLOOD	80% of all costs except non-replacement fees (blood deductible) for first 3 pints in each benefit period (after \$75 deductible/calendar year)	80% of costs except nonreplacement fees (blood deductible) for first 3 pints (after \$75 deductible/calendar year)		
-------	--	--	--	--

[Any other policy benefits not mentioned in this chart should be added to the chart in the order prescribed by the outline of coverage. If there are corresponding Medicare benefits, they should be shown.]

[Describe any coverage provisions changing due to Medicare modifications.]

[Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.]

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY [COMPANY] ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE HEALTH CARE FINANCING ADMINISTRATION. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT [Policy] CONTACT:

[COMPANY OR FOR AN INDIVIDUAL POLICY - NAME OF AGENT] [ADDRESS/PHONE NUMBER]

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6. --- Statement that the policy does or does not cover the following: ---

(a) --- Private duty nursing; ---

(b) --- Skilled nursing home care costs (beyond what is covered by Medicare); ---

(c) --- Custodial nursing home care costs; ---

(d) --- Intermediate nursing home care costs; ---

(e) --- Home health care above number of visits covered by Medicare; ---

(f) --- Physician charges (above Medicare's reasonable charges); ---

(g) --- Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay); ---

(h) --- Care received outside the U.S.A.; ---

(i) --- Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for the cost of eyeglasses or hearing aids. ---

7. --- A description of any policy provisions which exclude, eliminate, resist, reduce, limit, delay, or in any other manner operate to qualify payments of the benefits described in 4 above, including conspicuous statements: ---

(a) --- That the chart summarizing Medicare benefits only briefly describes such benefits. 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.

(b) --- That the Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations. ---

8. --- A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium. ---

9. --- The amount of premium for this policy. ---

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

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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, "Charts Describing Medicare Supplement Benefits Plans 'A' through 'J', Respectively" consisting of 22 pages. An issuer may use additional benefit plan designations on these charts pursuant to Section 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.

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

Any accident and sickness insurance policy or subscriber contract certificate, other than a Medicare supplement policy; or a policy issued pursuant to a contract under Section 1876 or Section 1833 of the federal Social Security Act (42 U.S.C. § 1395, et seq.); disability income policy; basic, catastrophic, or major medical expense policy; single premium nonrenewable policy or other policy identified in ~~Subsection 1.5(B)~~ Section 1.5(C) of this regulation, issued for delivery in this State to persons eligible for Medicare by reason of age shall notify insureds under the policy or subscriber-contract that the policy or subscriber-contract is not a Medicare supplement policy or certificate. Such notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy or subscriber contract, or if no outline of coverage is delivered, to the first page of the policy, or certificate or subscriber-contract delivered to insureds. Such notice shall be in no less than twelve (12) point type and shall contain the following language:

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"THIS [POLICY, OR CERTIFICATE OR SUBSCRIBER-CONTRACT] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company."

Section ~~12~~ 15. Requirements for Application Forms and Replacement Coverage

~~12~~ 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, ~~except where the coverage is sold without an agent,~~ containing such questions and statements may be used.

[Statements]

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

(B) If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(C) The benefits and premiums under your Medicare supplement policy will be suspended 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.

(D) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid.

[Questions]

To the best of your knowledge:

(A) Do you have another Medicare supplement insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

(1) If so, with which company?

~~(B) -- Did you have another Medicare supplement insurance policy or certificate in force during the last twelve (12) months?--~~

~~(1) -- If so, with which company?--~~

~~(2) -- If that policy lapsed, when did it lapse?--~~

(B) Do you have any other health insurance policies that provide benefits which this Medicare supplement policy would duplicate?

(1) If so, with which company?

(2) What kind of policy?

~~(C) -- Are you covered by Medicaid?--~~

~~(D) (C) If the answer to question A or B is yes, do you intend to replace any of your these medical or health insurance coverage policies with this policy [certificate]?~~

(D) Are you covered by Medicaid?

~~12-2~~ 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.

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~~12-9~~ 15.4 Upon determining that a sale will involve replacement of Medicare supplement coverage, an insurer or any issuer, other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a comparative information form, a benefit comparison form, and a notice regarding replacement of accident and sickness Medicare supplement coverage. One (1) copy of such forms and the notice signed as indicated in Sections 12.4 and 12.5 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 insurer. A direct response insurer issuer shall deliver to the applicant, at the time of the issuance of the policy, the comparative information form, the benefit comparison form, and the notice regarding replacement of accident and sickness Medicare supplement coverage.

~~12-4~~ 15.5 The comparative information form, benefit comparison form and notice required by Subsection 12.9 Section 15.4 above for an insurer, issuer other than a direct response insurer, shall be provided in substantially the following form in no less than ten (10) point type:

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COMPARATIVE INFORMATION FORM

Agent's Name _____ Address _____
Phone Number _____

Name of Proposed Insured _____ Address _____
Date of Birth _____

GENERAL INFORMATION

EXISTING INSURANCE

PROPOSED INSURANCE

GENERAL INFORMATION	EXISTING INSURANCE	PROPOSED INSURANCE
Name of Company	_____	_____
Policy Number	_____	_____
Basic Policy Generic Name	_____	_____
Name of Basic Policy	_____	_____
Rider 1; Generic Name	_____	_____
Rider 2; Generic Name	_____	_____
Rider 3; Generic Name	_____	_____
Issue Age	_____	_____
Date of Issue	_____	_____
Contestable Period Expires	_____	_____
Suicide Clause Expires	_____	_____
Pre-Existing Condition Expires	_____	_____
Free Look Period Expires	_____	_____

AGENT'S STATEMENT

1. The primary reasons for my recommending the proposed replacement of existing Medicare supplement insurance by new Medicare supplement insurance are:* _____

2. My recommendations as to the existing insurance is that it be:
 Lapsed
 Other (Explain) _____
3. Have you provided the proposed insured with an outline of coverage with their signature and date of receipt affixed? _____

* Specific reasons must be given. For example, if you believe the existing Medicare supplement insurance cannot meet the insured/buyer's needs, you must specify why you think it does not.

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BENEFIT COMPARISON FORM

<u>DOES THE POLICY COVER:</u>	<u>EXISTING INSURANCE</u>	<u>PROPOSED INSURANCE</u>
Medicare Part A hospital deductible?.....	_____	_____
Medicare Part A hospital daily co-payments?.....	_____	_____
Hospital Care Beyond Medicare's limits.....	_____	_____
Medicare Part B annual deductible?.....	_____	_____
Medicare Part B co-payments?.....	_____	_____
Medicare blood deductibles?....	_____	_____
Private hospital room?.....	_____	_____
Private hospital nurses?.....	_____	_____
Medical appliances such as eyeglasses and hearing aids?...	_____	_____
Custodial nursing home care?...	_____	_____
Is there a coordination of benefits provision?.....	_____	_____
Can the company cancel or non-renew the policy?.....	_____	_____
What are the policy limits for covered services?.....	_____	_____
What health conditions are excluded under the policy?.....	_____	_____
How often can the company raise the premium?.....	_____	_____
How long before existing health problems are covered?...	_____	_____
Does the policy have a waiting period? How long?.....	_____	_____

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BENEFIT COMPARISON FORM (cont.)

AGENT'S CERTIFICATION

I hereby certify that prior to taking an application for a policy, I have provided the applicant with the Notice Regarding Replacement of Medicare Insurance and the information in this Benefit Comparison Form is true and correct to the best of my knowledge and belief.

(Signature of Agent)

(Date)

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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 ~~lapse or otherwise~~ 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. ~~For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.~~

You should review this new coverage carefully, ~~comparing~~ Compare it with all accident and sickness coverage you now have, ~~and terminate~~ 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]:
(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. ~~I believe the~~ The replacement of insurance involved in this transaction ~~materially improves your position~~ does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s): My ~~conclusion has taken into account the following considerations, which I call to your attention:~~

Additional benefits.

No change in benefits, but lower premiums.

Fewer benefits and lower premiums.

Other. (please specify)

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1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

~~3. IF you are replacing existing Medicare supplement insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.~~

4. 3. If, after due consideration, 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, reread 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]

The above "Notice to Applicant" was delivered to me on:

(Date)

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(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

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.

~~12.5--The notice--required by Subsection 2.3--above--for a direct response insurers shall be as follows:~~

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COMPARATIVE INFORMATION FORM
(Insurance Company's Name and Address)

Authorized Company Representative's Name _____
Address _____
Phone Number _____

Name of Proposed Insured _____ Address _____
Date of Birth _____

GENERAL INFORMATION

EXISTING INSURANCE

PROPOSED INSURANCE

GENERAL INFORMATION	EXISTING INSURANCE	PROPOSED INSURANCE
Name of Company	_____	_____
Policy Number	_____	_____
Basic Policy Generic Name	_____	_____
Name of Basic Policy	_____	_____
Rider 1; Generic Name	_____	_____
Rider 2; Generic Name	_____	_____
Rider 3; Generic Name	_____	_____
Issue Age	_____	_____
Date of Issue	_____	_____
Contestable Period Expires	_____	_____
Suicide Clause Expires	_____	_____
Pre-Existing Condition Expires	_____	_____
Free Look Period Expires	_____	_____

AUTHORIZED COMPANY
REPRESENTATIVE'S STATEMENT

1. The primary reasons for recommending the proposed replacement of existing Medicare supplement insurance by new Medicare supplement insurance are:*

2. Recommended action as to the existing insurance is that it be:

Lapsed

Other (Explain) _____

3. Has the insurance company provided the proposed insured with an outline of coverage with their signature and date of receipt affixed? _____

* Specific reasons must be given. For example, if you believe the existing Medicare supplement insurance cannot meet the insured/buyer's needs, you must specify why you think it does not.

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BENEFIT COMPARISON FORM
(Insurance Company's Name and Address)

<u>DOES THE POLICY COVER:</u>	<u>EXISTING INSURANCE</u>	<u>PROPOSED INSURANCE</u>
Medicare Part A hospital deductible?.....	_____	_____
Medicare Part A hospital daily co-payments?.....	_____	_____
Hospital Care Beyond Medicare's limits.....	_____	_____
Medicare Part B annual deductible?.....	_____	_____
Medicare Part B co-payments?.....	_____	_____
Medicare blood deductibles?....	_____	_____
Private hospital room?.....	_____	_____
Private hospital nurses?.....	_____	_____
Medical appliances such as eyeglasses and hearing aids?...	_____	_____
Custodial nursing home care?...	_____	_____
Is there a coordination of benefits provision?.....	_____	_____
Can the company cancel or non-renew the policy?.....	_____	_____
What are the policy limits for covered services?.....	_____	_____
What health conditions are excluded under the policy?.....	_____	_____
How often can the company raise the premium?.....	_____	_____
How long before existing health problems are covered?...	_____	_____
Does the policy have a waiting period? How long?.....	_____	_____

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BENEFIT COMPARISON FORM (cont.)

AUTHORIZED COMPANY
REPRESENTATIVE'S CERTIFICATION

I hereby certify that prior to taking an application for a policy, I have provided the applicant with the Notice Regarding Replacement of Medicare Insurance and the information in this Benefit Comparison Form is true and correct to the best of my knowledge and belief.

(Signature of Authorized
Company Representative)

(Date)

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 lapse or otherwise terminate existing Medicare supplement insurance and replace it with the policy delivered herewith issued by [Company Name] Insurance Company. Your new policy provides thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

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. Your insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing Medicare supplement insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. [To be included only if the application is attached to the policy.]

If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could

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~~cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.~~

~~-----
(Company Name)-----~~

Section ~~13~~ 16. Filing Requirements for Advertising

~~13.1~~ **16.1** Every insurer, health care service plan or other entity providing An issuer Medicare supplement insurance or benefits in this State 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 West Virginia Code §33-6-8(e), §33-6-35, and §33-11-4(2).

Section ~~14~~ 17. Standards for Marketing

~~14.1~~ **17.1** Every insurer, health care service plan or other entity marketing An issuer Medicare supplement insurance coverage in this State, 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) --- Establish marketing procedures which set forth a mechanism or formula for determining whether a replacement policy or certificate contains benefits clearly and substantially greater than the benefits under the replaced policy for purposes of triggering first-year commissions as authorized in Section 10 of this regulation.~~

~~(B)~~ (C) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer: This policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations." -- your medical expenses."

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~~(E)~~ (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.

~~(F)~~ (E) ~~Every insurer or entity marketing Medicare supplement insurance shall establish~~ Establish auditable procedures for verifying compliance with this Section ~~14-1~~ 17.1.

~~14-2~~ 17.2 In addition to the practices prohibited in this State's unfair trade practices act [West Virginia Code §33-11-1, et seq.], the following acts and practices are prohibited:

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

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

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

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.

Section ~~15-~~ 18. Appropriateness of Recommended Purchase and Excessive Insurance

~~15-1~~ 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.

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~~15-2 18.2 Any sale of Medicare supplement coverage which that will provide an individual more than one Medicare supplement policy or certificate is prohibited; provided, however, that additional Medicare supplement coverage may be sold if, when combined with that individual's health coverage already in force, it would insure no more than 100% of the individual's actual medical expenses covered under the combined policies.~~

Section 16~~r~~ 19. Reporting of Multiple Policies

~~16-1 19.1 On or before March 1 of each year, every insurer or other entity providing an issuer Medicare supplement insurance coverage in this State shall report the following information for every individual resident of this State for which whom the insurer or entity issuer has in force more than one Medicare supplement insurance policy or certificate:~~

- (A) Policy and certificate number, and
- (B) Date of issuance.

~~16-2 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."

Section 17~~r~~ 20. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates

~~17-1 20.1 If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing insurer issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy.~~

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 for benefits similar to those contained in the original policy or certificate.

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Section ~~18~~ 21. Separability

~~18-1~~ 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.

[COMPANY NAME]

NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT COVERAGE - 1990

THE FOLLOWING CHART BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ THIS CAREFULLY.

[A BRIEF DESCRIPTION OF THE REVISIONS TO MEDICARE PARTS A & B WITH A PARALLEL DESCRIPTION OF SUPPLEMENTAL BENEFITS WITH SUBSEQUENT CHANGES, INCLUDING DOLLAR AMOUNTS, PROVIDED BY THE MEDICARE SUPPLEMENT COVERAGE IN SUBSTANTIALLY THE FOLLOWING FORMAT.]

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	In 1989 Medicare Pays Per Calendar Year	Effective January 1, 1990, Medicare Will Pay	In 1989 Your Coverage Pays	Effective January 1, 1990. Your Coverage Will Pay
MEDICARE PART A SERVICES AND SUPPLIES				
Inpatient Hospital Services	Unlimited number of hospital days after \$560 deductible	All but \$592 for first 60 days/benefit period		
Semi-Private Room & Board		All but \$148 a day for 61st-90th days/benefit period		
Misc. Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room		All but \$296 a day for 91st-150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)		
BLOOD	Pays all costs except payment of deductible (equal to costs for first 3 pints) each calendar year. Part A blood deductible reduced to the extent paid under Part B	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in each calendar year		

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	<u>In 1989 Medicare Pays Per Calendar Year</u>	<u>Effective January 1, 1990, Medicare Will Pay</u>	<u>In 1989 Your Coverage Pays</u>	<u>Effective January 1, 1990, Your Coverage Will Pay</u>
SKILLED NURSING FACILITY CARE	There is no prior confinement requirement for this benefit	100% of costs for first 20 days (after a 3 day prior hospital confinement)/ benefit period		
	First 8 days - All but \$25.50 a day	All but \$74.00 a day for 21st-100th days/benefit period		
	9th through 150th day - 100% of costs	Beyond 100 days - Nothing/benefit period		
	Beyond 150 days - Nothing			
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after \$75 deductible)	80% of allowable charges (after \$75 deductible/ calendar year)		
PRESCRIPTION DRUGS	Inpatient prescription drugs. 80% of allowable charges for immuno- suppressive drugs during the first year following a covered trans- plant (after \$75 deductible/ calendar year)	Inpatient prescription drugs. 80% of allowable charges for immunosup- pressive drugs during the first year following a covered transplant (after \$75 deductible/calendar year)		

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SERVICES

MEDICARE BENEFITS

YOUR MEDICARE SUPPLEMENT COVERAGE

In 1989
 Medicare Pays
 Per Calendar Year

Effective January 1,
 1990, Medicare Will Pay

In 1989
 Your Coverage
 Pays

Effective January 1, 1990,
 Your Coverage Will Pay

BLOOD

80% of all costs
 except non-
 replacement fees
 (blood
 deductible) for
 first 3 pints in
 each benefit
 period (after \$75
 deductible/
 calendar year)

80% of costs except
 nonreplacement fees
 (blood deductible) for
 first 3 pints (after \$75
 deductible/calendar year)

[Any other policy benefits not mentioned in this chart should be added to the chart in the order prescribed by the outline of coverage. If there are corresponding Medicare benefits, they should be shown.]

[Describe any coverage provisions changing due to Medicare modifications.]

[Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.]

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY [COMPANY] ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE HEALTH CARE FINANCING ADMINISTRATION. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT [Policy] CONTACT:

[COMPANY OR FOR AN INDIVIDUAL POLICY - NAME OF AGENT]

[ADDRESS/PHONE NUMBER]

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (w) _____
 For the State of _____
 Company Name _____
 MAIC Group Code _____ MAIC Company Code _____
 Person Completing This Exhibit _____
 Title _____ Telephone Number _____

Line	(a) Earned Premium (x) -----	(b) Incurred Claims(y) -----
1 Current Year's Experience		
a. Total (all policy years)		
b. Current year's issues (z)		
c. Net (for reporting purposes = 1a - 1b)	-----	-----
2 Past Years' Experience (All Policy Years)	-----	-----
3 Total Experience (Net Current Year + Past Years' Experience)	-----	-----
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
Tot. Earned Prem.(line 3, col a) - Refunds Since Inception(line 6)		
9 Life Years Exposed Since Inception _____		

If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.

10 Tolerance Permitted (obtained from credibility table) _____

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE _____ SWSBP (w) _____
For the State of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____

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 =

(Tot. 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.

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 - 999	15.0%

If less than 500, no credibility.

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (w) _____

For the State of _____

Company Name _____

MAIC Group Code _____ MAIC Company Code _____

- (w) "SMSBP" = Standardized Medicare Supplement Benefit Plan
- (x) Includes modal loadings and fees charged.
- (y) Excludes Active Life Reserves.
- (z) This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

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

Signature

Name - Please Type

Title

Date

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

FOR CALENDAR YEAR _____
TYPE _____ SWSBP (p)

FOR THE STATE OF _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(k) Policy Year Loss Ratio
1	2,770	2.770	0.442	0.442	0.000	0.000	0.000	0.000	0.000	0.4
2	4,175	4.175	0.493	0.493	0.000	0.000	0.000	0.000	0.000	0.53
3	4,175	4.175	0.493	0.493	1.194	1.194	0.659	0.659	0.659	0.65
4	4,175	4.175	0.493	0.493	2.245	2.245	0.669	0.669	0.669	0.67
5	4,175	4.175	0.493	0.493	3.170	3.170	0.676	0.676	0.676	0.69
6	4,175	4.175	0.493	0.493	3.998	3.998	0.686	0.686	0.686	0.71
7	4,175	4.175	0.493	0.493	4.754	4.754	0.695	0.695	0.695	0.73
8	4,175	4.175	0.493	0.493	5.445	5.445	0.702	0.702	0.702	0.75
9	4,175	4.175	0.493	0.493	6.075	6.075	0.708	0.708	0.708	0.76
10	4,175	4.175	0.493	0.493	6.650	6.650	0.713	0.713	0.713	0.76
11	4,175	4.175	0.493	0.493	7.176	7.176	0.717	0.717	0.717	0.76
12	4,175	4.175	0.493	0.493	7.655	7.655	0.720	0.720	0.720	0.77
13	4,175	4.175	0.493	0.493	8.093	8.093	0.723	0.723	0.723	0.77
14	4,175	4.175	0.493	0.493	8.493	8.493	0.725	0.725	0.725	0.77
15	4,175	4.175	0.493	0.493	8.684	8.684	0.725	0.725	0.725	0.77
Total:		(k):	(l):	(l):	(m):	(m):	(n):	(n):	(n):	

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

(a): Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2
(etc.)
(b): For the calendar year on the appropriate line in column (m), the premium earned during that year for policies issued in that year.

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

(c): 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.
(p): SWSBP = Standardized Medicare Supplement Benefit Plan

Appendix A

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

FOR CALENDAR YEAR _____ SMSBP (p)

TYPE _____
FOR THE STATE OF _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(k) Policy Year Loss Ratio
1	2,770	4.175	11,474	0.507	5,814	0.000	0.000	0.000	0.000	0.46
2	4,175	4.175	17,434	0.567	10,121	0.000	0.000	0.000	0.000	0.63
3	4,175	4.175	17,434	0.567	10,121	1.194	5,000	0.759	3,750	0.75
4	4,175	4.175	17,434	0.567	10,121	2.245	9,375	0.771	7,730	0.77
5	4,175	4.175	17,434	0.567	10,121	3.170	13,238	0.782	7,920	0.8
6	4,175	4.175	17,434	0.567	10,121	3.998	16,700	0.792	8,350	0.82
7	4,175	4.175	17,434	0.567	10,121	4.754	19,844	0.802	8,600	0.84
8	4,175	4.175	17,434	0.567	10,121	5.445	22,744	0.811	8,800	0.87
9	4,175	4.175	17,434	0.567	10,121	6.075	25,354	0.818	9,000	0.88
10	4,175	4.175	17,434	0.567	10,121	6.650	27,754	0.824	9,200	0.88
11	4,175	4.175	17,434	0.567	10,121	7.176	30,164	0.828	9,400	0.88
12	4,175	4.175	17,434	0.567	10,121	7.655	32,364	0.831	9,600	0.88
13	4,175	4.175	17,434	0.567	10,121	8.093	34,000	0.834	9,800	0.89
14	4,175	4.175	17,434	0.567	10,121	8.493	35,464	0.837	10,000	0.89
15	4,175	4.175	17,434	0.567	10,121	8.884	37,000	0.838	10,200	0.89
Totals:		(k):	(l):	(m):	(n):					

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

(a): Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2
(etc.)
(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

(c): 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.

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

(p): SMSBP = Standardized Medicare Supplement Benefit Plan

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

Signature

Name and Title (please type)

Date

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 91st 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	\$ 0 All but \$157 a day All but \$314 a day \$ 0 \$ 0	\$ 0 \$ 157 a day \$ 314 a day 100% of Medicare Eligible Expenses \$ 0	\$628 (Part A Deductible) \$ 0 \$ 0 \$ 0 ALL COSTS
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$78.50 a day \$ 0	\$ 0 \$ 0 \$ 0	\$ 0 Up to \$78.50 a day ALL COSTS
BLOOD First 3 pints Additional amounts	\$ 0 100%	3 pints \$ 0	\$ 0 \$ 0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out- patient drugs and inpatient respite care	\$ 0	Balance

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

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

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 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	\$ 0 All but \$157 a day All but \$314 a day \$ 0 \$ 0	\$628 (Part A Deductible) \$ 157 a day \$ 314 a day 100% of Medicare Eligible Expenses \$ 0	\$ 0 \$ 0 \$ 0 \$ 0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$78.50 a day \$ 0	\$ 0 \$ 0 \$ 0	\$ 0 Up to \$78.50 a day All costs
BLOOD First 3 pints Additional amounts	\$ 0 100%	3 pints \$ 0	\$ 0 \$ 0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out- patient drugs and inpatient respite care	\$ 0	Balance

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 tests, durable medical equipment, *First \$100 of Medicare Approved Amounts* *(the Part B Deductible) Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$ 0 80% \$ 0	\$ 0 20% \$ 0	\$100 \$ 0 All Costs
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	100% \$ 0 80%	\$ 0 \$ 0 20%	\$ 0 \$100 (Part B Deductible) \$ 0
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PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 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	\$ 0 All but \$157 a day All but \$314 a day \$ 0 \$ 0	\$628 (Part A Deductible) \$ 157 a day \$ 314 a day 100% of Medicare Eligible Expenses \$ 0	\$ 0 \$ 0 \$ 0 \$ 0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$78.50 a day \$ 0	\$ 0 Up to \$78.50 a day \$ 0	\$ 0 \$ 0 All costs
BLOOD First 3 pints Additional amounts	\$ 0 100%	3 pints \$ 0	\$ 0 \$ 0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out- patient drugs and inpatient respite care	\$ 0	Balance

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 tests, durable medical equipment, First \$100 of Medicare Approved Amounts* (the Part B Deductible) Remainder of Medicare Approved Amounts Part B Excess Charges(Above Medicare Approved Amounts)	\$ 0 80% \$ 0	\$100 20% \$ 0	\$ 0 \$ 0 All Costs
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	100% \$ 0 80%	\$ 0 \$100 (Part B Deductible) 20%	\$ 0 \$ 0 \$ 0
OTHER BENEFITS			
FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically necessary emergency care services 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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 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	\$ 0 All but \$157 a day All but \$314 a day \$ 0 \$ 0	\$628 (Part A Deductible) \$ 157 a day \$ 314 a day 100% of Medicare Eligible Expenses \$ 0	\$ 0 \$ 0 \$ 0 \$ 0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$78.50 a day \$ 0	\$ 0 Up to \$78.50 a day \$ 0	\$ 0 \$ 0 All costs
BLOOD First 3 pints Additional amounts	\$ 0 100%	3 pints \$ 0	\$ 0 \$ 0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out- patient drugs and inpatient respite care	\$ 0	Balance

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 tests, durable medical equipment, First \$100 of Medicare Approved Amounts* (the Part B Deductible) Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$ 0 80% \$ 0	\$ 0 20% \$ 0	\$100 \$ 0 All Costs
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	100% \$ 0 80%	\$ 0 \$ 0 20%	\$ 0 \$100 (Part B Deductible) \$ 0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (must be received within 8 weeks of last Medicare Approved visit) - Calendar year maximum	\$ 0 \$ 0 \$ 0	Actual Charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week \$ 1,600	Balance

OTHER BENEFITS

FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically necessary emergency care services 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 \$50,000 lifetime maximum
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PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 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	\$ 0 All but \$157 a day All but \$314 a day \$ 0 \$ 0	\$628 (Part A Deductible) \$ 157 a day \$ 314 a day 100% of Medicare Eligible Expenses \$ 0	\$ 0 \$ 0 \$ 0 \$ 0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$78.50 a day \$ 0	\$ 0 Up to \$78.50 a day \$ 0	\$ 0 \$ 0 All costs
BLOOD First 3 pints Additional amounts	\$ 0 100%	3 pints \$ 0	\$ 0 \$ 0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out- patient drugs and inpatient respite care	\$ 0	Balance

PLAN E
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 tests, durable medical equipment, First \$100 of Medicare Approved Amounts* (the Part B Deductible) Remainder of Medicare Approved Amounts Part B Excess Charges(Above Medicare Approved Amounts)	\$ 0 80% \$ 0	\$ 0 20% \$ 0	\$ 100 \$ 0 All Costs
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$ 0	\$ 0
HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder	100% \$ 0 80%	\$ 0 \$ 0 20%	\$ 0 \$ 100 (Part B Deductible) \$ 0

PARTS A & B

OTHER BENEFITS

PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE 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	\$ 0 \$ 0	\$ 120 \$ 0	\$ 0 All Costs
FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically necessary emergency care services 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 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
HOSPITALIZATION* 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	\$ 0 All but \$157 a day All but \$314 a day \$ 0 \$ 0	\$628 (Part A Deductible) \$ 157 a day \$ 314 a day 100% of Medicare Eligible Expenses \$ 0	\$ 0 \$ 0 \$ 0 \$ 0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$78.50 a day \$ 0	\$ 0 Up to \$78.50 a day \$ 0	\$ 0 \$ 0 All Costs
BLOOD First 3 pints Additional amounts	\$ 0 100%	3 pints \$ 0	\$ 0 \$ 0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out- patient drugs and inpatient respite care	\$ 0	Balance

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 tests, durable medical equipment, First \$100 of Medicare Approved Amounts* (the Part B Deductible) Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$ 0 80% \$ 0	\$100 20% 100%	\$ 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	100% \$ 0 80%	\$ 0 \$100 (Part B Deductible) 20%	\$ 0 \$ 0 \$ 0
OTHER BENEFITS			
FOREIGN TRAVEL--NOT COVERED BY MEDICARE Medically necessary emergency care services 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
HOSPITALIZATION* 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	\$ 0 All but \$157 a day All but \$314 a day \$ 0 \$ 0	\$628 (Part A Deductible) \$ 157 a day \$ 314 a day 100% of Medicare Eligible Expenses \$ 0	\$ 0 \$ 0 \$ 0 \$ 0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$78.50 a day \$ 0	\$ 0 Up to \$78.50 a day \$ 0	\$ 0 \$ 0 All costs
BLOOD First 3 pints Additional amounts	\$ 0 100%	3 pints \$ 0	\$ 0 \$ 0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive those services	All but very limited coinsurance for out- patient drugs and inpatient hospice care	\$ 0	Balance

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts* (the Part B Deductible) Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$ 0 80% \$ 0	\$ 0 20% 80%	\$100 \$ 0 20%
CLINICAL LABORATORY SERVICES-BLOOD TESTS OR 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	100% \$ 0 80%	\$ 0 \$ 0 20%	\$ 0 \$100 (Part B Deductible) \$ 0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (must be received within 8 weeks of last Medicare Approved visit) - Calendar year maximum	\$ 0 \$ 0 \$ 0	Actual Charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week \$ 1,600	Balance

OTHER BENEFITS

FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically necessary emergency care services 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
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MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 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	\$ 0 All but \$157 a day All but \$314 a day \$ 0 \$ 0	\$628 (Part A Deductible) \$ 157 a day \$ 314 a day 100% of Medicare Eligible Expenses \$ 0	\$ 0 \$ 0 \$ 0 \$ 0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$78.50 a day \$ 0	\$ C Up to \$78.50 a day \$ C	\$ 0 \$ 0 All costs
BLOOD First 3 pints Additional amounts	\$ 0 100%	3 pints \$ 0	\$ 0 \$ 0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out- patient drugs and inpatient respite care	\$ 0	Balance

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

* Since 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 tests, durable medical equipment, First \$100 of Medicare Approved Amounts* (the Part B Deductible) Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$ 0 80% \$ 0	\$ 0 20% \$ 0	\$100 \$ 0 All Costs
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$ 0	\$ 0

PARTS A & B

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

PLAN H

OTHER BENEFITS

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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	\$ 0 \$ 0 \$ 0	\$ 0 50% - \$1,250 calendar year maximum benefit \$ 0	\$ 250 50% All Costs
FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically necessary emergency care services 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 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
HOSPITALIZATION* 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	\$ 0 All but \$157 a day All but \$314 a day \$ 0 \$ 0	\$628 (Part A Deductible) \$ 157 a day \$ 314 a day 100% of Medicare Eligible Expenses \$ 0	\$ 0 \$ 0 \$ 0 \$ 0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$78.50 a day \$ 0	\$ 0 Up to \$78.50 a day \$ 0	\$ 0 \$ 0 All costs
BLOOD First 3 pints Additional amounts	\$ 0 100%	3 pints \$ 0	\$ 0 \$ 0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out- patient drugs and inpatient hospice 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 tests, durable medical equipment, First \$100 of Medicare Approved Amounts* (the Part B Deductible) Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$ 0 80% \$ 0	\$ 0 20% 100%	\$100 \$ 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 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 - Number of visits covered (must be received within 8 weeks of last Medicare Approved visit) - Calendar year maximum	100% \$ 0 80%	\$ 0 \$ 0 20%	\$ 0 \$100 (Part B Deductible) \$ 0 Balance
	\$ 0	Actual Charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week \$ 1,600	

PLAN I

OTHER BENEFITS

<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>
<p>FORIGN TRAVEL-NOT COVERED BY MEDICARE Medically necessary emergency care services 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 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	YOUR PAY
HOSPITALIZATION* Semi-private 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	\$ 0 All but \$157 a day All but \$314 a day \$ 0 \$ 0	\$628 (Part A Deductible) \$ 157 a day \$ 314 a day 100% of Medicare Eligible Expenses \$ 0	\$ 0 \$ 0 \$ 0 \$ 0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First: 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$78.50 a day \$ 0	\$ 0 Up to \$78.50 a day \$ 0	\$ 0 \$ 0 All costs
BLOOD First 3 pints Additional amounts	\$ 0 100%	3 pints \$ 0	\$ 0 \$ 0
HOSPICK CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out- patient drugs and inpatient respite care	\$ 0	Balance

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 PAYE	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts* (the Part B Deductible) Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$ 0 80% \$ 0	\$100 20% 100%	\$ 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	100% \$ 0 80%	\$ 0 \$100 (Part B Deductible) 20%	\$ 0 \$ 0 \$ 0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$ 0	Actual Charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week \$ 1,600	Balance
- Calendar year maximum	\$ 0		

PLAN J

OTHER BENEFITS

<p>EXTENDED OUTPATIENT PRESCRIPTION DRUGS-NOT COVERED BY MEDICARE First \$250 each calendar year Next \$6,000 each calendar year Over \$6,000 each calendar year</p>	<p>\$ 0 \$ 0 \$ 0</p>	<p>\$ 0 \$ 0 \$ 0</p>	<p>\$ 250 50% All Costs</p>
<p>PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE Annual physical and preventive tests and services, such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, digstick ucinalysis, 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>\$ 120 \$ 0</p>	<p>\$ 0 \$ 0</p>	<p>\$ 0 All Costs</p>
<p>FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically necessary emergency care services 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 \$ 0</p>	<p>\$ 250 20% and amounts over the \$50,000 lifetime maximum \$50,000 lifetime maximum benefit of \$ 50,000</p>

ATTACHMENT TO QUESTION 2(d) :

Comments concerning this proposed rule were received from: Colonial Penn Life Insurance Company; American Family Life Assurance Company of Columbus (AFLAC); the Health Insurance Association of America (HIAA); Mutual of Omaha Insurance Company; Combined Insurance Company of America; and National Home Life Assurance Company.

National Home Life commented on Sections 3.6(B) and 4.1(F) of the Insurance Commissioner's agency-adopted rule filed on January 18, 1991 as an emergency rule. The insurer opined that these sections should specifically address treatment in governmental hospitals. This suggestion is now moot, in light of the July 12, 1991 revisions to the National Association of Insurance Commissioners "Model Regulation to Implement NAIC Medicare Supplement Insurance Minimum Standards Model Act." Those revisions strike the provisions about which National Home Life complained. These strike-throughs have been incorporated by the Insurance Commissioner in the agency-approved rule that is now being filed.

The Commissioner's prior approval of premium modifications as set forth in Section 6.1(A)(3) of the agency-adopted rule also sparked a comment by National Home Life. That insurance company expressed concern that this provision could place time constraints on the insurance industry and the Commissioner alike, in light of changes in the federal Medicare law which are often enacted late in the year. However,

the Commissioner has prior approval authority over premium rates pursuant to various sections of the West Virginia Code, and this regulatory provision (now renumbered Section 5.1(A)(3) in the agency-approved rule) merely reiterates this statutory authority.

Nearly all of the above-named commentators criticized the 70% loss ratio for individual Medicare supplement policies, which standard was used in Section 8.1(B) of the Insurance Commissioner's agency-adopted rule filed as an emergency rule on January 18, 1991. The commentators maintained that this 70% loss ratio would prevent them from operating profitably, and that this could adversely affect the availability of Medicare supplement insurance for West Virginia residents. In response to these comments and consistent with the loss ratio standards adopted by the NAIC in its July 12, 1991 final draft of its model rule, the Insurance Commissioner has revised this proposed rule. Section 11.1(B) of the proposed rule now employs a 65% loss ratio standard for individual Medicare supplement policies. (Section 11.1(A) of the revised proposed rule adopts the 75% loss ratio standard recommended by the NAIC for group policies.)

Agent compensation provisions contained in Section 10 of the agency-adopted rule filed January 18, 1991 also generated comments from most of the aforementioned insurance companies and the HIAA. Many of the commentators requested that the Insurance Commissioner replace the five-year level commission provisions in Section 10 with the 200% first-year commission allowed in the NAIC's model Medicare supplement insurance rule. However, the

NAIC model rule disallows any first-year commission if an existing policy is replaced by a new Medicare supplement policy. The Insurance Commissioner has legal authority to adopt a more stringent standard for agent and producer compensation than that employed in the NAIC model rule. Therefore, the Commissioner has decided to retain in renumbered Section 13.1 of this proposed rule the more stringent five-year level commission standard for permitted compensation arrangements.

AFLAC and Mutual of Omaha also commented on technical points relating to the wording of Sections 10.1, 10.2 and 10.3 in the Insurance Commissioner's agency-adopted rule filed in January. The language used therein is adopted from the NAIC's model rule. The Insurance Commissioner does not deem it necessary or advisable to change this wording, which appears in renumbered Sections 13.1, 13.2 and 13.3 of the agency-approved rule.

The Insurance Commissioner's custom-designed comparative information form and benefit comparison form used in Sections 12.3 and 12.4 of the agency-adopted rule filed in January, 1991 also generated comments from the HIAA, Mutual of Omaha and National Home Life Insurance Company. These commentators pointed out certain ambiguities in these two sections of the agency-adopted rule, and they also criticized the use of these custom-designed forms that deviated from the NAIC model rule. Therefore, in renumbered Sections 15.4 and 15.5 of the agency-approved rule, the Insurance Commissioner has

adopted the NAIC's model rule language and forms (found in Section 16 of the NAIC's July 12, 1991 draft model rule) relating to required disclosure provisions for Medicare supplement insurance policies or certificates.



STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

Legal Division

GASTON CAPERTON
Governor

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HANLEY C. CLARK
Insurance Commissioner

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

HAND-DELIVERED

November 8, 1991

Michael P. McThomas, Esquire
Associate Counsel
Legislative Rule-Making
Review Committee
State Capitol
Charleston, West Virginia 25305

Re: Series 24 of the West Virginia Insurance
Commissioner's Legislative Rules, "Permanent
Rules on Medicare Supplement Insurance"

Dear Mike:

This letter is a followup to our August 5, 1991 and September 26, 1991 telephone conversations regarding the above-captioned agency-approved rule and a parallel emergency rule now pending before the Legislative Rule-Making Review Committee (LRMRC).

Pursuant to our aforesaid telephone conversations, enclosed please find copies of the following documents that contain background information relating to the Insurance Commissioner's most recent Medicare supplement insurance regulations:

(1) The July 12, 1991 draft "Model Regulation to Implement the NAIC [National Association of Insurance Commissioners] Medicare Supplement Insurance Minimum Standards Model Act." This draft model rule was used as the basis for the Insurance Commissioner's agency-approved rule on Medicare supplement insurance, filed with the West Virginia Secretary of State's Office and the LRMRC on July 17, 1991. July 17 was the 180th day following the January 18, 1991 initial filing of the Commissioner's emergency rule entitled "Permanent Regulations to Implement Changes in Medicare Supplement Insurance to Conform to Medicare Catastrophic Coverage Repeal Act of 1989." Due to the 180-day deadline mandated by the then applicable

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provisions of West Virginia Code § 29A-3-15(a)(3), the Insurance Commissioner was unable to wait until the NAIC adopted the final draft of its model Medicare supplement insurance rule during a plenary session conducted by telephone conference call on July 30, 1991. The above-cited provisions of the West Virginia Administrative Procedures Act required the Insurance Commissioner to file his agency-approved Medicare supplement insurance rule, which meets the standards required by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) amendments to the federal Medicare statutes, no later than July 17, 1991.

(2) A document reflecting changes incorporated in the NAIC's July 30, 1991 adopted Model Act and Model Regulation on Medicare supplement insurance. The strike-throughs and underscoring on the non-sequentially numbered pages contained in this document reflect changes in the July 12, 1991 draft Model Act and Regulation prior to adoption of the final versions of that act and regulation on July 30, 1991. During an October 29, 1991 telephone conversation with Carole Olson Gates, Assistant to the Executive Vice President of the NAIC, I inquired whether there had been any substantive changes in the July 12 final draft of the Model Regulation prior to its July 30 adoption. Ms. Gates stated that the only substantive changes had been made in the charts describing the ten standardized Medicare supplement insurance benefit plans, and in the Outline of Coverage. Therefore, the Insurance Commissioner requests the permission of the LRMRC to make those necessary changes in both its agency-approved Medicare supplement insurance rule and in the parallel emergency rule (as amended on August 2, 1991).

(3) The November 1, 1990 Memorandum by Gary Claxton of the NAIC to Kevin Cronin, the NAIC's Washington counsel, summarizing the OBRA '90 amendments to the federal Medicare statute and the effect of those amendments on state regulatory programs regarding Medicare supplement insurance.

(4) An August 30, 1991 Memorandum to all state insurance commissioners from the United States Department of Health & Human Services, Health Care Financing Administration (HCFA), which Memorandum addresses the subject of "Procedures and Timeframes Required for Approval of State Programs under the Omnibus Budget Reconciliation Act of 1990 (OBRA '90)."

(5) A bound document dated September 1991 and prepared by the NAIC, entitled "The Omnibus Budget Reconciliation Act of 1990 and Its Effect on State Regulatory Programs for Medicare Supplement Insurance, Book 2." The portions of this booklet which may be most helpful to you

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include Section I ("Answers to Frequently Asked Questions"), Section II ("Section by Section Analysis of Medicare Supplement Model Act and Regulation"), and Section III ("OBRA 1990 Cross Referenced to NAIC Model Act and Regulation").

(6) An October 16, 1991 Memorandum from Earl R. Pomeroy, the chairman of the NAIC's Medicare Supplement and Other Limited Benefit Plans Task Force, to all NAIC members regarding Medicare supplement insurance changes effective November 5, 1991 pursuant to the OBRA '90 federal law amendments.

As we discussed previously by telephone, the Insurance Commissioner's agency-approved Medicare supplement insurance rule and the parallel emergency rule as amended on August 2, 1991 both incorporate the OBRA '90 "simplification" standards required by federal law for Medicare supplement insurance policies. However, that agency-approved rule (filed July 17, 1991) was also filed as a step in implementing regulations to conform with previous requirements established by the federal Medicare Catastrophic Coverage Repeal Act (MCCRA) of 1989. The Insurance Commissioner's initial rule incorporating the MCCRA of 1989 requirements was filed as an emergency rule on January 18, 1991 and was subsequently amended on an emergency basis on February 22, 1991. By letter to the Insurance Commissioner dated June 7, 1991, Barbara Gagel of HCFA notified the Commissioner that HCFA had approved West Virginia's Medicare supplement insurance regulatory program based upon that emergency rule containing the MCCRA of 1989 standards.

Due to rule-making deadlines established in West Virginia Code §§ 29A-3-1 et seq., and the fact that the West Virginia Legislature's only 1992 Regular Session will convene in January, the Insurance Commissioner had to file on July 17, 1991 his agency-approved Medicare supplement insurance regulations incorporating the OBRA '90 requirements. Those OBRA '90 standards must be in effect in each State no later than July 30, 1992, in order for the State to avoid federal takeover of its Medicare supplement insurance regulatory program.

Prior to the Insurance Commissioner filing his agency-approved Medicare supplement insurance rule on July 17, 1991, I spoke by telephone conference call with Director Marc Thomas of HCFA's Division of Operational Initiatives, Bureau of Program Operations and with Attorney Gary Claxton of the NAIC. Messrs. Thomas and Claxton agreed that the MCCRA of 1989 standards were included in the July 12, 1991 draft Model Regulation of the NAIC, which also incorporated the OBRA '90

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requirements. Because the Insurance Commissioner's agency-approved Medicare supplement insurance rule filed July 17 was based on that July 12 draft Model Regulation of the NAIC, that agency-approved rule fulfilled two purposes: (1) meeting the MCCRA of 1989 requirements, and (2) launching a proposed regulation incorporating the OBRA '90 federal standards on the path toward authorization by the full West Virginia Legislature in time to meet the aforementioned July 30, 1992 deadline for each State to implement the OBRA '90 requirements in its regulatory scheme governing Medicare supplement insurance.

On August 2, 1991, the Insurance Commissioner filed a Second Emergency Amendment to his emergency Medicare supplement insurance rule with both the West Virginia Secretary of State and the LRMRC. The Secretary of State's Office rendered an Emergency Rule Decision putting that amended emergency rule into effect on August 5, 1991. In that amended emergency rule, we again followed the July 12 draft Model Regulation of the NAIC which incorporated the OBRA '90 requirements for Medicare supplement insurance. However, we also corrected some typographical errors found in the agency-approved rule filed July 17, 1991, and we renumbered certain of the Appendices filed with the agency-approved rule. For that reason, during my August 5, 1991 telephone conversation with you, we agreed that you should work from the August 2 amended emergency rule in preparing your abstract of the Insurance Commissioner's proposed Medicare supplement insurance rule for the LRMRC.

During that same telephone conversation, you asked me to state in this letter why we had agreed that the Insurance Commissioner need not run a public comment period on the agency-approved rule filed July 17, 1991 which implemented the OBRA '90 requirements on Medicare supplement insurance. When we filed the initial proposed rule implementing the MCCRA requirements on January 18, 1991, we ran a public comment period as required by the Administrative Procedures Act rule-making provisions contained in West Virginia Code Chapter 29A, Article 3. We took those comments into consideration and made certain changes based on them, particularly in Section 11 of the agency-approved rule relating to the loss ratios under which insurance companies marketing Medicare supplement insurance policies in West Virginia are required to operate. However, the agency-approved rule filed on July 17 differed very significantly in other respects from the proposed Medicare supplement insurance regulations filed January 18, 1991, due to the fact that the initial proposed rule had to meet the MCCRA of 1989 federal law requirements and the agency-approved rule filed on July 17, 1991 needed to incorporate the standards

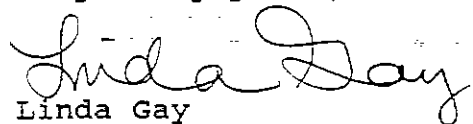
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November 8, 1991

established in the OBRA '90 amendments to the federal Medicare statutes.

The principal factors which led you and I to conclude during our August 5, 1991 telephone conversation that the Insurance Commissioner need not run a public comment period on the agency-approved Medicare supplement insurance rule filed on July 17, 1991 were as follows: (1) I had conferred by telephone with Ms. Cooper of the Secretary of State's office on that issue, and she and then Deputy Secretary of State Robert Wilkinson had concluded after reviewing the provisions of West Virginia Code Chapter 29A, Article 3 that those statutes did not require another public comment period to be run on that rule; (2) the provisions in the agency-approved Medicare supplement rule that differed significantly from those in the initial proposed rule filed in January 1991 were mandated by the OBRA '90 amendments to the federal Medicare statutes, which were passed by Congress in October 1990; and (3) the Insurance Commissioner's agency-approved rule was based on the NAIC's Model Regulation that implemented the OBRA '90 standards for Medicare supplement insurance. That Model Regulation had been the subject of numerous exposure drafts disseminated to the insurance industry through July 1991. Because the insurance industry had had a number of months to comment upon the NAIC Model Regulation, which was redrafted several times, you and I agreed that the Insurance Commissioner need not notice a public comment period on the agency-approved Medicare supplement insurance rule. In addition, the Insurance Commissioner and his staff were concerned that if we did run another 30-day public comment period beginning on July 17, 1991 when the agency-approved rule was filed, that comment period would have extended past the August 12, 1991 deadline for filing another agency-approved rule that would be assured of consideration by the full Legislature during its 1992 Regular Session.

I hope that the information contained in this letter and its enclosures will be helpful to you. Please do not hesitate to call me at 348-0401 if you have any questions.

Very truly yours,


Linda Gay
Associate General Counsel

LG/iw

Enclosures

cc: Ms. Judy Cooper (without enclosures)