

WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #2

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OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF A COMMENT PERIOD ON A PROPOSED RULE

AGENCY: Insurance Commissioner TITLE NUMBER: 114

RULE TYPE: Legislative; CITE AUTHORITY _____

AMENDMENT TO AN EXISTING RULE: YES NO

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 24

TITLE OF RULE BEING AMENDED: Transitional Requirements for the Con-
version of Medicare Supplement Insurance Benefits and Premiums to
Conform to Medicare Program Revisions

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

TITLE OF RULE BEING PROPOSED: _____
Requirements for Medicare Supplement Insurance Benefits and Premiums
to Conform to Medicare Program Revisions

IN LIEU OF A PUBLIC HEARING, A COMMENT PERIOD HAS BEEN ESTABLISHED DURING WHICH ANY INTERESTED PERSON MAY SEND COMMENTS CONCERNING THESE PROPOSED RULES. THIS COMMENT PERIOD WILL END ON September 18, 1989 AT 4:30 p.m.

ONLY WRITTEN COMMENTS WILL BE ACCEPTED AND ARE TO BE MAILED TO THE FOLLOWING ADDRESS.

B. Keith Huffman, Esq.

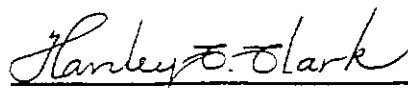
General Counsel

Office of the Insurance Commissioner

2019 Washington Street, East

Charleston, WV 25305

THE ISSUES TO BE HEARD SHALL BE LIMITED TO THIS PROPOSED RULE.


Hanley C. Clark
Insurance Commissioner

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL



State of West Virginia
Department of Tax and Revenue

Charleston 25305

GASTON CAPERTON
GOVERNOR

CHARLES O. LORENSEN
SECRETARY

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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: Chapter 33-28; Series 24; Requirements for Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions.

Signed this 14th day of August, 1989.

A handwritten signature in cursive script, reading "Charles O. Lorensen", written over a horizontal line.

CHARLES O. LORENSEN
Secretary of Tax and Revenue

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WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

CHAPTER 33-28
SERIES 24

REQUIREMENTS FOR MEDICARE SUPPLEMENT
INSURANCE BENEFITS AND PREMIUMS TO CONFORM
TO MEDICARE PROGRAM REVISIONS

- Section 1. General
- Section 2. Definitions
- Section 3. Policy Definitions and Terms
- Section 4. Prohibited Policy Provisions
- Section 5. Minimum Benefit Standards
- Section 6. Standards for Claims Payment
- Section 7. Loss Ratio Standards
- Section 8. Filing Requirements for Out-of-State Group Policies
- Section 9. Prohibited Compensation for Replacement with the Same Company
- Section 10. Required Disclosure Provisions
- Section 11. Requirements for Replacement
- Section 12. Filing Requirements for Advertising
- Section 13. Separability

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WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

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CHAPTER 33-28
SERIES 24

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

REQUIREMENTS FOR MEDICARE SUPPLEMENT
INSURANCE BENEFITS AND PREMIUMS TO CONFORM
TO MEDICARE PROGRAM REVISIONS

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 Medicare Program Revisions," filing and effective date September 20, 1988, 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:

(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 or 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 combination thereof, for employees or

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former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

Section 2. Definitions

2.1 "Applicant" means:

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

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

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

2.3 "Medicare Supplement Policy" means a group or individual policy of [accident and sickness] insurance or a subscriber contract [of hospital and medical service associations or health maintenance organizations] 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.

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

Section 3. Policy Definitions and Terms

3.1 No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy unless such policy or subscriber contract 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 restrictive than as that defined in the Medicare program.

3.4 "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall be defined in relation to its status, facilities and available services.

(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) maintains 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.

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3.5 "Health Care Expenses" means expenses of health maintenance organizations associated with the delivery of health care services which are analogous to incurred losses of insurers.

Such expenses shall not include:

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

(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:

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- (1) convalescent homes, convalescent, rest or nursing facilities; or
- (2) facilities primarily affording custodial, educational or rehabilitory care; or
- (3) facilities for the aged, drug addicts or alcoholics.

3.7 "Medicare" shall be defined in the policy. 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 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 "Physician" may be defined by including words such 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 "Sickness" shall not be defined to be more restrictive than the following:

"Sickness means sickness 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;

(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) eye glasses, 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), (I), 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.

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

Section 5. Minimum Benefit Standards

5.1 No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy which does not meet 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.

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

(1) A Medicare supplement policy may not deny a claim for losses incurred more than six (6) months from the effective date of coverage for a preexisting condition. The policy 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.

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

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

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

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

(5) Termination of a Medicare supplement policy 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 payment of the maximum benefits.

(B) Minimum Benefit Standards.

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

(2) Coverage for the daily copayment amount of Medicare Part A eligible expenses for the first eight (8) days per calendar year incurred for skilled nursing facility care.

(3) Coverage 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) under Medicare Part A unless replaced in accordance with federal regulations.

(4) (a) Until January 1, 1990, coverage for twenty-percent of the amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of \$200 of such expenses and to a maximum benefit of at least \$5,000 per calendar year.

(b) Effective January 1, 1990, coverage for the copayment amount of Medicare eligible expenses excluding outpatient prescription drugs under Medicare Part B regardless of hospital confinement up to the maximum out-of-pocket amount for Medicare Part B after the Medicare deductible amount.

(5) 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.

(6) Effective January 1, 1990, coverage for the copayment amount of Medicare eligible expenses for covered home intravenous (IV) therapy drugs (as determined by the Secretary of Health and Human Services) subject to the Medicare outpatient prescription drug deductible amount, if applicable.

(7) Effective January 1, 1990, coverage for the copayment amount of Medicare eligible expenses for outpatient drugs used in immunosuppressive therapy, subject to the Medicare outpatient prescription drug deductible, if applicable.

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(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. Standards for Claims Payment

6.1 Every entity providing 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).

6.2 Compliance with the requirements set forth in Subsection 6.1 above must be certified on the Medicare supplement insurance experience reporting form.

Section 7. Loss Ratio Standards

7.1 All filings of rates and rating schedules shall demonstrate that actual and expected losses in relation to premiums comply with the requirements of this section. Medicare supplement policies shall return to policyholders in the form of aggregate benefits under the policy, for the entire period for which rates are computed to provide coverage, 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:

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

(B) At least 60 percent of the aggregate amount of premiums earned in the case of individual policies.

(C) Every entity providing Medicare supplement policies 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 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.

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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 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.

(D) As soon as practicable, but no later than sixty (60) days prior to the effective date of Medicare benefit changes required by the Medicare Catastrophic Coverage Act of 1988, every insurer, health care service plan or other entity providing Medicare supplement insurance or contracts in this State, shall file with the commissioner, in accordance with the applicable filing procedures of this State:

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

Every insurer, health care service plan or other entity providing 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 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 for such Medicare supplement insurance policies or contracts. 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. Premium adjustments shall be in the form of refunds or premium credits and shall be made no later than upon renewal if a credit is given, or within sixty (60) days of the renewal date or anniversary date if a refund is provided to the premium payer. Premium adjustments shall be calculated for the period commencing with Medicare benefit changes.

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

Section 8. Filing Requirements for Out-of-State Group Policies

8.1 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 9. Prohibited Compensation for Replacement with the Same Company

9.1 No entity shall provide compensation to its agents or other producers which is greater than the renewal compensation which would have been paid on an existing policy if the existing policy is replaced by another policy with the same company where the new policy benefits are substantially similar to the benefits under the old policy and the old policy was issued by the same insurer or insurer group.

Section 10. Required Disclosure Provisions

10.1 General Rules.

(A) Medicare supplement policies shall include a renewal, continuation or nonrenewal provision. The language or specifications of such provision must be consistent with the type of contract to be issued. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, or renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(B) Except for riders or endorsements by which the insurer 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

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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 issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must 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 policy which provides 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 contains any limitations with respect to preexisting conditions, such limitations must 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 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 accident and sickness policies, 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 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. Delivery of the Buyer's Guide shall be made whether or not such policies, certificates or subscriber contracts are advertised, solicited or issued as Medicare supplement policies as defined in this regulation.

Except in the case of direct response insurers, 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. Direct response insurers shall deliver the Buyer's Guide to the applicant upon request, but not later than at the time the policy is delivered.

10.2 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 entity providing Medicare supplement insurance or benefits to a resident of this State shall notify its policyholders, contract holders and certificate holders of modifications it has made to Medicare supplement insurance policies or contracts in a format acceptable to the commissioner. For the years 1989 and 1990 and if prescription drugs are covered in 1991, such notice shall be in a format prescribed by the commissioner or in the format prescribed in Appendixes A, B and C if no other format is prescribed by the commissioner. In addition, 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, and

(2) Inform each covered person 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.

10.3 Outline of Coverage Requirements for Medicare Supplement Policies.

(A) Insurers issuing 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 and, except for direct response policies, shall obtain an acknowledgment of receipt of such outline from the applicant; and

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(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 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 Paragraph (2) shall be in the form prescribed below:

[COMPANY NAME]
OUTLINE OF MEDICARE
SUPPLEMENT COVERAGE

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!
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].
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.

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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:]

THIS POLICY YOU PAY
PAYS

DESCRIPTION

SERVICE

PART A

INPATIENT HOSPITAL SERVICES:

Semi-Private Room & Board

Miscellaneous Hospital Services
& Supplies, such as Drugs,
X-Rays, Lab Tests & Operating Room

SKILLED NURSING FACILITY CARE

BLOOD

PARTS A & B

Home Health Services

PARTS B

MEDICAL EXPENSE:

Services of a Physician/
Outpatient Services

Medical Supplies other than
Prescribed Drugs

BLOOD

MAMMOGRAPHY SCREENING

OUT-OF-POCKET MAXIMUM

PRESCRIPTION DRUGS

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MISCELLANEOUS

Home IV-Drug Therapy

Immunosuppressive Drugs

Respite Care Benefits

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.

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

Part A

MEDICARE BENEFITS IN

<u>Service</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
PART A				
Inpatient Hospital Services:	All but \$540 for first 60 days/benefit period	All but [\$564] deductible for an unlimited number of days/calendar year	All but Part A deductible for an unlimited number of days/calendar year	All but Part A deductible for an unlimited number of days/calendar year
Semi-Private Room & Board	All but \$135 a day for 61st-90th days/benefit period			
Miscellaneous Hospital Services & Supplies, such as Drugs, X-rays, Lab Tests & Operating Room	All but \$270 a day for 91st-150th days (if the individual chooses to use 60 nonrenewable lifetime reserve days)			
	Nothing beyond 150 days			

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Part A

MEDICARE BENEFITS IN

(cont'd)

<u>Service</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
PART A				
Skilled Nursing Facility Care	100% of costs for 1st 20 days (after a 3 day prior hospital confinement)	80% of Medicare reasonable costs for first 8 days per calendar year w/out prior hospitalization requirement	80% for first 8 days/calendar year	80% for first 8 days/calendar year
	All but \$67.50 a day for 1st-100th days			
	Nothing beyond 100 days	100% of costs thereafter up to 150 days/calendar year	100% for 9th-150th day/calendar year	100% for 9th-150th day/calendar year
Blood	Pays all costs except non- replacement fees (blood deductible) for first 3 pints in <u>each benefit period</u>	Pays all costs except payment of deductible (equal to costs for first 3 pints) <u>each</u> <u>calendar year.</u> Part A blood deductible reduced to the extent paid under Part B	All but blood deductible (equal to costs for first 3 pints)	All but blood deductible (equal to costs for first 3 pints)

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Part B

MEDICARE BENEFITS IN

<u>Service</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
Parts A & B:				
Home Health Services	Intermittent skilled nursing care and other services in the home (daily skilled nursing care for up to 21 days or longer in some cases)—100% of covered services and 80% of durable medical equipment under both Parts A & B	Same as '88	Intermittent skilled nursing care for up to 7 days a week for up to 38 days allowing for continuation of services under unusual circumstances; other services,—100% of covered services and 80% of durable medical equipment under both Parts A & B	Same as '90
PART B				
Medical Expense: Services of a Physician/Outpatient Services	80% of reasonable charges after an annual \$75 deductible	80% after annual \$75 deductible	80% of reasonable charges after \$75 annual deductible until out-of-pocket maximum is reached. 100% of reasonable charges are covered for remainder of calendar year	Same as '90
Medical Supplies Other than Prescribed Drugs				
Blood	80% of costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period after \$75 deductible	Pays 80% of all costs except payment of deductible (equal to costs for first 3 pints) <u>each calendar year</u>	Same as '89	Same as '89

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Part B

MEDICARE BENEFITS IN

(cont'd)

<u>Service</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
Mammography Screening			80% of approved charge for elderly and disabled Medicare beneficiaries - exams available every other year for women 65 & over	Same as '90
Out-of-Pocket Maximum			\$1,370 consisting of Part B \$75 deductible, Part B blood deductible and 20% co-insurance	\$1,370—will be adjusted annually by Secretary of Health and Human Services
Outpatient Prescription Drugs			There is a \$550 total deductible applicable to home IV drug and immunosuppressive drug therapies as noted below	Covered after \$600 deductible subject to 50% co-insurance
Home IV-Drug Therapy			80% of IV therapy drugs subject to \$550 deductible (deductible waived if home therapy is a continuation of therapy initiated in a hospital)	80% of IV therapy drugs subject to standard drug deductible (deductible waived if home therapy is a continuation of therapy drugs initiated in a hospital)
Immunosuppressive Drug Therapy	80% of costs during first year following a covered organ transplant (no special drug deductible; only the regular Part B deductible)	Same as '88	Same as '88 for first year following covered transplant; 50% of costs during 2nd and following years (subject to \$550 deductible)	Same as '90 (subject to \$600 deductible)

PART B

MEDICARE BENEFITS IN

(cont'd)

<u>Service</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
Respite Care Benefit			In-home care for chronically dependent individual covered for up to 80 hours after either the out-of-pocket limit or the outpatient drug deductible has been met	Same as '90

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.

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- (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.

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

10.4 Notice Regarding Policies or Subscriber Contracts Which Are Not Medicare Supplement Policies.

Any accident and sickness insurance policy or subscriber contract, other than a Medicare supplement policy; disability income policy; basic, catastrophic, or major medical expense policy; single premium nonrenewable policy or other policy identified in Section 1.3(B) 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. 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, 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:

"THIS [POLICY, 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 11. Requirements for Replacement

11.1 Application forms shall include a question designed to elicit information as to 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 containing such a question may be used.

11.2 Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of

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the Medicare supplement policy or certificate, a notice regarding replacement of accident and sickness coverage. One (1) copy of such notice shall be provided to the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of accident and sickness coverage. In no event, however, will such a notice be required in the solicitation of "accident only" and "single premium nonrenewable" policies.

11.3 The notice required by Subsection 11.2 above for an insurer, other than a direct response insurer, shall be provided in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be 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.

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.

DRAFTING NOTE: This subsection may be modified if preexisting conditions are covered under the new policy.

2. 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.
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/health history. Failure to include all material medical

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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 it carefully to be certain that all information has been properly recorded.

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

(Date)

(Applicant's Signature)

11.4 The notice required by Subsection 11.2 above for a direct response shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

According to [your application] [information you have furnished] you intend to lapse or otherwise terminate existing accident and sickness 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.

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. 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.

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3. [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 cause an otherwise valid claim to be denied. Carefully check the application and write to [Company Name and Address] within ten (10) 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 12. Filing Requirements for Advertising

12.1 Every insurer, health care service plan or other entity providing 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 13. Separability

13.1 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.

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Appendix A

[COMPANY NAME]

NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT INSURANCE - 1989

YOUR HEALTH CARE BENEFITS PROVIDED BY THE FEDERAL MEDICARE PROGRAM WILL CHANGE BEGINNING JANUARY 1, 1989. ADDITIONAL CHANGES WILL OCCUR IN MEDICAL BENEFITS IN FOLLOWING YEARS. THE MAJOR CHANGES ARE SUMMARIZED BELOW. THESE CHANGES WILL AFFECT HOSPITAL, MEDICAL AND OTHER SERVICES AND SUPPLIES PROVIDED UNDER MEDICARE. BECAUSE OF THESE CHANGES, YOUR MEDICARE SUPPLEMENT COVERAGE PROVIDED BY [COMPANY NAME] WILL CHANGE, ALSO. THE FOLLOWING OUTLINE BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ 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	
	Medicare Now Pays Per Benefit Period	Effective January 1, 1989 Medicare Will Pay Per Calendar Year	Your 1988 Coverage Per Benefit Period	Effective January 1, 1989 Your Coverage Will Pay Per Calendar year
MEDICARE PART A SERVICES AND SUPPLIES	First 60 days - All but \$540 61st to 90th day - All but \$135 a day 91st to 150th day - All but \$270 a day (if individual chooses to use 60 nonrenew- able lifetime reserve days) Beyond 150th day - Nothing	Unlimited number of hospital days after \$560 deductible.		

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	<u>Medicare Now Pays Per Benefit Period</u>	<u>Effective January 1, 1989 Medicare Will Pay Per Calendar Year</u>	<u>Your 1988 Coverage Per Benefit Period</u>	<u>Effective January 1, 1989 Your Coverage Will Pay Per Calendar year</u>
SKILLED NURSING FACILITY CARE	Requires a 3 day prior stay and enter facility generally within 30 days after hospital discharge.	There is no prior confinement requirement for this benefit.		
	First 20 days - All but \$25.50 a day	First 8 days -		
	21st through 100th day - All but \$67.50 a day	9th through 150th day - 100% of costs		
	Beyond 100 days - Nothing	Beyond 150 days - Nothing		

MEDICARE BENEFITS YOUR MEDICARE SUPPLEMENT COVERAGE

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	Medicare Now Pays Per Calendar Year	In 1989 Medicare Part B Pays the Same as in 1988	Your Policy Now Pays	Effective January 1, 1989 Your Policy Will Pay
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after \$75 deductible)	NOTE: Medicare Benefits changes on January 1, 1990 as follows: 80% of allowable charges (after \$75 deductible) until an annual Medicare Catastrophic limit is met. 100% of allowable charges for the remainder of the calendar year. The limit in 1990 is \$1,370* and will be adjusted on an annual basis.		
PRESCRIPTION DRUGS	Inpatient prescription drugs only	In 1989 Medicare covers inpatient prescription drugs only.		
		Effective January 1, 1990 Per Calendar Year 80% of allowable charges for home intravenous (IV) therapy drugs and 50% of allowable charges for immunosuppressive drugs after (\$550 in 1990) calendar year deductible is met.		

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<u>Medicare Now Pays Per Calendar Year</u>	<u>In 1989 Medicare Part B Pays the Same as in 1988</u>	<u>Your Policy Now Pays</u>	<u>Effective January 1, 1989 Your Policy Will Pay</u>
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Effective January 1, 1991
Per Calendar Year
 Inpatient prescription
 drugs: 50% of allowable
 charges for all other
 outpatient prescription
 drugs after a \$600
 calendar year deductible
 is met (the deductible
 will change). Coverage
 will increase to 60% of
 allowable charges in 1992
 and to 80% of allowable
 charges from 1993 on.

*Expenses that count toward the Part B Medicare Catastrophic Limit include: the Part B deductible and copayment charges and the Part B blood deductible charges.

[ANY ADDITIONAL BENEFITS]

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

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

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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Appendix B

[COMPANY NAME]

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

YOUR HEALTH CARE BENEFITS PROVIDED BY THE FEDERAL MEDICARE PROGRAM WILL CHANGE BEGINNING JANUARY 1, 1990. ADDITIONAL CHANGES WILL OCCUR IN MEDICAL BENEFITS IN FOLLOWING YEARS. THE MAJOR CHANGES ARE SUMMARIZED BELOW. THESE CHANGES WILL AFFECT HOSPITAL, MEDICAL AND OTHER SERVICES AND SUPPLIES PROVIDED UNDER MEDICARE. BECAUSE OF THESE CHANGES, YOUR MEDICARE SUPPLEMENT COVERAGE PROVIDED BY [COMPANY NAME] WILL CHANGE, ALSO. THE FOLLOWING OUTLINE 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	
		Effective January 1, 1990 Medicare Will Pay Per Calendar Year	Effective January 1, 1990 Your Coverage Will Pay Per Calendar year
MEDICARE PART A SERVICES AND SUPPLIES	Unlimited number of hospital days after \$560 deductible	Medicare Now Pays Per Calendar Year	Your Coverage Now Pays Per Calendar Year
SKILLED NURSING FACILITY CARE	There is no prior confinement requirement for this benefit		
	First 8 days - All but \$25.50 a day		
	9th through 150th day - 100% of costs		
	Beyond 150 days - Nothing		

SERVICES

MEDICARE BENEFITS

YOUR MEDICARE SUPPLEMENT COVERAGE

	Medicare Now Pays Per Calendar Year	Effective January 1, 1990 Medicare Will Pay Per Calendar Year	Your Coverage Now Pays Per Calendar Year	Effective January 1, 1990 Your Coverage Will Pay Per Calendar Year
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after \$75 deductible)	80% of allowable charges (after \$75 deductible) until an annual Medicare Catastrophic Limit* is met. 100% of allowable charges for the remainder of the calendar year. The limit in 1990 is \$1370 and will be adjusted on an annual basis.		
PRESCRIPTION DRUGS	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive therapy drugs during the first year following covered transplant.	Inpatient prescription drugs. 80% of allowable charges for home intravenous (IVM) therapy drugs and 50% of allowable charges for immunosuppressive drugs after (\$550 in 1990) calendar year deductible is met.		

*Expenses that you must pay out-of-pocket and that count toward the Part B Medicare Catastrophic Limit include: the Part B deductible and copayment charges and the Part B blood deductible charges.

[ANY ADDITIONAL BENEFITS]

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

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

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Appendix B

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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Appendix C

[COMPANY NAME]

NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT COVERAGE - 1991

YOUR HEALTH CARE BENEFITS PROVIDED BY THE FEDERAL MEDICARE PROGRAM WILL CHANGE BEGINNING JANUARY 1, 1991. ADDITIONAL CHANGES WILL OCCUR IN MEDICAL BENEFITS IN FOLLOWING YEARS. THE MAJOR CHANGES ARE SUMMARIZED BELOW. THESE CHANGES WILL AFFECT HOSPITAL, MEDICAL AND OTHER SERVICES AND SUPPLIES PROVIDED UNDER MEDICARE. BECAUSE OF THESE CHANGES, YOUR MEDICARE SUPPLEMENT COVERAGE PROVIDED BY [COMPANY NAME] WILL CHANGE, ALSO. THE FOLLOWING OUTLINE BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ 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	
		Effective January 1, 1990 Your Coverage Now Pays Per Calendar Year	Effective January 1, 1991 Your Coverage Will Pay Per Calendar year
MEDICARE PART A SERVICES AND SUPPLIES	Unlimited number of hospital days after \$[] deductible		
SKILLED NURSING FACILITY CARE	There is no prior confinement requirement for this benefit		
	First 8 days - All but \$[] a day		
	9th through 150th day - 100% of costs		
	Beyond 150 days - Nothing		

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Appendix C

SERVICES

MEDICARE BENEFITS

YOUR MEDICARE SUPPLEMENT COVERAGE

	Medicare Now Pays Per Calendar Year	Effective January 1, 1991 Medicare Will Pay Per Calendar Year	Your Coverage Now Pays Per Calendar Year	Effective January 1, 1991 Your Coverage Will Pay Per Calendar year
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after \$75 deductible) until an annual Medicare Catastrophic Limit* is met. 100% of allowable charges for the remainder of the calendar year. The limit in 1990 is \$1370 and will be adjusted on an annual basis.	80% of allowable charges (after \$75 deductible) until an annual Medicare Catastrophic Limit* is met. 100% of allowable charges for the remainder of the calendar year. The limit in 1991 is \$[] and will be adjusted on an annual basis.		
PRESCRIPTION DRUGS	Inpatient prescription drugs. 80% of allowable charges for home IV therapy drugs and 50% of allowable charges for immunosuppressive drugs, after a \$550 calendar year deductible is met.	Same as 1990 and 50% of allowable charges for all other outpatient prescription drugs after \$600 calendar year deductible is met.		

*Expenses that you must pay out-of-pocket and that count toward the Part B Medicare Catastrophic Limit include: the Part B deductible and copayment charges and the Part B blood deductible charges.

[ANY ADDITIONAL BENEFITS]

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Appendix C

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

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

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]