

3901-8-08

Medicare supplement.**(A) Purpose**

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

(B) Authority

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

(C) Applicability and scope

(1) Except as otherwise specifically provided in paragraphs (G), (O), (P), (S), and (X) of this rule, this rule shall apply to:

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

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

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

(D) Definitions

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

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

(2) "Bankruptcy" means when a "Medicare Advantage" organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

(3) "Certificate" means any certificate delivered or issued for delivery in this state

under a group medicare supplement policy.

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

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

(6)

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

(i) A group health plan;

(ii) Health insurance coverage;

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

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

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

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

(vii) A state health benefits risk pool;

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

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

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

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

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

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

- (iii) Liability insurance, including general liability insurance and automobile liability insurance;
 - (iv) Workers' compensation or similar insurance;
 - (v) Automobile medical payment insurance;
 - (vi) Credit-only insurance;
 - (vii) Coverage for on-site medical clinics; and
 - (viii) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (c) "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
 - (i) Limited scope dental or vision benefits;
 - (ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
 - (iii) Such other similar, limited benefits as are specified in federal regulations.
- (d) "Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:
 - (i) Coverage only for a specified disease or illness; and
 - (ii) Hospital indemnity or other fixed indemnity insurance.
- (e) "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:
 - (i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the "Social Security Act";
 - (ii) Coverage supplemental to the coverage provided under chapter 55 of "Title 10, United States Code"; and
 - (iii) Similar supplemental coverage provided to coverage under a group health plan.

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

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

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

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

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

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

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

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

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

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

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

(a) Coordinated care plans which provide health care services, including but not limited to health insuring corporation plans (with or without a

point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

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

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

(13) "Medicare supplement policy" means a group or individual policy of sickness and accident insurance or a subscriber contract of health insuring corporations, other than a policy issued pursuant to a contract under section 1876 of the federal "Social Security Act" (42 U.S.C. section 1395 et. seq.) or an issued policy under a demonstration project specified in 42 U.S.C. 1395 ss (g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under medicare for the hospital, medical or surgical expenses of persons eligible for medicare. "Medicare supplement policy" does not include "Medicare Advantage" plans established under medicare "Part C", "Outpatient Prescription Drug" plans established under medicare "Part D", or any "Health Care Prepayment Plan (HCPP)" that provides benefits pursuant to an agreement under section 1833(a)(1)(A) of the "Social Security Act".

(14) "Pre-Standardized Medicare supplement benefit plan," "Pre-Standardized benefit plan" or "Pre-Standardized plan" means a group or individual policy of medicare supplement insurance issued prior to May 1, 1992.

(15) "1990 Standardized Medicare supplement benefit plan," "1990 Standardized benefit plan" or "1990 plan" means a group or individual policy of medicare supplement insurance issued on or after May 1, 1992 and with an effective date for coverage prior to June 1, 2010 and includes medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

(16) "2010 Standardized Medicare supplement benefit plan," "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of medicare supplement insurance with an effective date for coverage on or after June 1, 2010.

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

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

(E) Policy definitions and terms

No policy or certificate may be advertised, solicited or issued for delivery in this

state as a medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of paragraph (E) of this rule.

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

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

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

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

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

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

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

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

(7) "Medicare-eligible expenses" shall mean expenses of the kinds covered by

medicare, "Parts A" and "B", to the extent recognized as reasonable and medically necessary by medicare.

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

(9) "Sickness" shall not be defined to be more restrictive than the following:

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

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

(F) Policy provisions

(1) Except for permitted preexisting condition clauses as described in paragraphs (G)(1)(a), (H)(1)(a), and (I)(1)(a) of this rule, no policy or certificate may be advertised, solicited or issued for delivery in this state as a medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of medicare.

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

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

(4)

(a) Subject to paragraphs (G)(1)(d), (G)(1)(e), (G)(1)(g), and paragraphs (H)(1)(d) and (H)(1)(e) of this rule, a medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in "Part D" at the option of the policyholder.

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

(c) After December 31, 2005, a medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in medicare "Part D" unless:

(i) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the

effective date of the individual's coverage under a "Part D" plan and;

- (ii) Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of medicare "Part D" enrollment, accounting for any claims paid, if applicable.

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

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

(1) General standards.

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

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

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

- (c) A medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

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

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

- (ii) Be cancelled or nonrenewed by the issuer solely on the grounds of

deterioration of health.

(e)

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

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

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

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

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

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

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

(iv) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy, such coverage to be effective the date the preceding policy terminates. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(f) Termination of a medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of medicare "Part D" benefits will not be considered in

determining a continuous loss.

(g) If a medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003", the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

(2) Minimum benefit standards.

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

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

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

(d) Upon exhaustion of all medicare hospital inpatient coverage including the lifetime reserve days, coverage of at least ninety per cent of all medicare "Part A" eligible expenses for hospitalization not covered by medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five days.

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

(f) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of medicare-eligible expenses under "Part B" regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the medicare "Part B" deductible [one hundred ten dollars].

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

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

for coverage prior to June 1, 2010.

The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state on or after May 1, 1992 and with an effective date for coverage prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards.

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

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

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

(c) A medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes, in accordance with paragraph (Q)(3)(b) of this rule.

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

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

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

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

(iii) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under paragraph

- (H)(1)(e)(v) of this rule, the issuer shall offer each certificate holder an individual medicare supplement policy which (at the option of the certificate holder)
- (a) Provides for continuation of the benefits contained in the group policy, or
- (b) Provides for benefits that otherwise meet the requirements of this subsection.
- (iv) If an individual is a certificate holder in a group medicare supplement policy and the individual terminates membership in the group, the issuer shall
- (a) Offer the certificate holder the conversion opportunity described in paragraph (H)(1)(e)(iii) of this rule, or
- (b) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.
- (v) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.
- (vi) If a medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the "Medicare Prescription Drug, Improvement and Modernization Act of 2003," the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.
- (f) Termination of a medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of medicare "Part D" benefits will not be considered in determining a continuous loss.
- (g)
- (i) A medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be

suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under "Title XIX of the Social Security Act," but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within ninety days after the date the individual becomes entitled to assistance.

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

(iii) Each medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the "Social Security Act" and is covered under a group health plan (as defined in section 1862 (b)(1)(A)(v) of the "Social Security Act"). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of the coverage within ninety days after the date of loss.

(iv) Reinstitution of such coverages:

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

(b) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of such suspension. If the suspended medicare supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for medicare "Part D" enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(c) Shall provide for classification of premiums on terms at least

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

(h) If an issuer makes a written offer to the medicare supplement policyholders or certificate holders of one or more of its plans, to exchange during a specified period from his or her 1990 standardized plan (as described in paragraph (J) of this rule) to a 2010 standardized plan (as described in paragraph (K) of this rule), the offer and subsequent exchange shall comply with the following requirements:

(i) An issuer need not provide justification to the superintendent if the insured replaces a 1990 standardized policy or certificate with an issue age rated 2010 standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the prefunding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the superintendent in accordance with paragraph (Q) of this rule.

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

(iii) An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 standardized policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six months to any added benefits contained in the new 2010 standardized policy or certificate not contained in the exchanged policy.

(iv) The new policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

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

Every issuer shall make available to each prospective insured a policy or certificate including only the following basic "core" package of benefits. An issuer may make available to prospective insureds any of the other medicare supplement insurance benefit plans in addition to the basic "core" package, but not in lieu of it.

- (a) Coverage of "Part A" medicare-eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period;
 - (b) Coverage of "Part A" medicare-eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used;
 - (c) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred per cent of the medicare "Part A" eligible expenses for hospitalization paid at the applicable prospective payment system ("PPS") rate, or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;
 - (d) Coverage under medicare "Parts A" and "B" for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
 - (e) Coverage for the coinsurance amount or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of medicare eligible expenses under "Part B" regardless of hospital confinement, subject to the medicare "Part B" deductible.
- (3) Standards for additional benefits. The following additional benefits shall be included in medicare supplement benefit plans "B" through "J" only as provided by paragraph (J) of this rule.
 - (a) Medicare "Part A" deductible: coverage for all of the medicare "Part A" inpatient hospital deductible amount per benefit period.
 - (b) Skilled nursing facility care: coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a medicare benefit period for post-hospital skilled nursing facility care eligible under medicare "Part A";
 - (c) Medicare "Part B" deductible: coverage for all of the medicare "Part B" deductible amount per calendar year regardless of hospital confinement.
 - (d) Eighty per cent of the medicare "Part B" excess charges: coverage for eighty per cent of the difference between the actual medicare "Part B" charge as billed, not to exceed any charge limitation established by the

medicare program or state law, and the medicare-approved "Part B" charge.

- (e) One hundred per cent of the medicare "Part B" excess charges: coverage for all of the difference between the actual medicare "Part B" charge as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved "Part B" charge.
- (f) Basic outpatient prescription drug benefit: coverage for fifty per cent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible, to a maximum of one thousand two hundred fifty dollars in benefits received by the insured per calendar year, to the extent not covered by medicare. The outpatient prescription drug benefit may be included for sale or issuance in a medicare supplement policy until January 1, 2006.
- (g) Extended outpatient prescription drug benefit: coverage for fifty per cent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible to a maximum of three thousand dollars in benefits received by the insured per calendar year, to the extent not covered by medicare. The outpatient prescription drug benefit may be included for sale or issuance in a medicare supplement policy until January 1, 2006.
- (h) Medically necessary emergency care in a foreign country: coverage to the extent not covered by medicare for eighty percent of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by medicare if provided in the "United States" and which care began during the first sixty consecutive days of each trip outside the "United States", subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.
- (i) Preventive medical care benefit: coverage for the following preventive health services not covered by medicare:

 - (i) An annual clinical preventive medical history and physical examination that may include tests and services from paragraph (H)(3)(i)(ii) of this rule and patient education to address preventive health care measures:
 - (ii) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by

the attending physician.

Reimbursement shall be for the actual charge up to one hundred per cent of the medicare approved amount for each service, as if medicare were to cover the service as identified in "American Medical Association" current procedural terminology ("AMA CPT") codes, to a maximum of one hundred twenty dollars annually under this benefit. This benefit shall not include payment for any procedure covered by medicare.

(j) At-home recovery benefit: coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

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

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

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

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

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

(ii) Coverage requirements and limitations

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

(b) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are

necessary because of a condition for which a home care plan of treatment was approved by medicare.

(c) Coverage is limited to:

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

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

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

(iv) Seven visits in any one week.

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

(vi) Services provided by a care provider as defined in paragraph (H)(3)(j) of this rule.

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

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

(iii) Coverage is excluded for:

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

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

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

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

- (i) Coverage of one hundred per cent of the "Part A" hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any medicare benefit period;
- (ii) Coverage of one hundred per cent of the "Part A" hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any medicare benefit period;
- (iii) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred per cent of the medicare "Part A" eligible expenses for hospitalization paid at the applicable prospective payment system ("PPS") rate, or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;
- (iv) Medicare "Plan A" deductible: coverage for fifty per cent of the medicare "Part A" inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (H)(4)(a)(x) of this rule;
- (v) Skilled nursing facility care coverage for fifty per cent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a medicare benefit period for post-hospital skilled nursing facility care eligible under medicare "Part A" until the out-of-pocket limitation is met as described in subparagraph (H)(4)(a)(x) of this rule;
- (vi) Hospice care coverage for fifty per cent of cost sharing for all "Part A" medicare-eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (H)(4)(a)(x) of this rule;
- (vii) Coverage for fifty per cent under medicare "Parts A" or "B", of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph (H)(4)(a)(x) of this rule;
- (viii) Except for coverage provided in subparagraph (H)(4)(a)(ix) of this rule, coverage for fifty per cent of the cost sharing otherwise applicable under medicare "Part B" after the policyholder pays the "Part B" deductible until the out-of-pocket limitation is met as

described in subparagraph (H)(4)(a)(x) of this rule:

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

(x) Coverage of one hundred per cent of all cost sharing under medicare "Parts A" and "B" for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under medicare "Parts A" and "B" of four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the "United States" department of health and human services.

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

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

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

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

(I) Benefit standards for 2010 standardized medicare supplement benefit plan policies or certificates issued or delivered with an effective date for coverage on or after June 1, 2010.

The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 standardized medicare supplement benefit plan for sale on or after the June 1, 2010 effective date of these 2010 standardized medicare supplement benefit plan standards in this state. Benefit standards applicable to medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010 remain subject to the requirements of paragraph (H) of this rule.

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

(a) A medicare supplement policy or certificate shall not exclude or limit

benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended or received from a physician within six months before the effective date of coverage.

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

(c) A medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

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

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

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

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

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

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

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

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

(a) Offer the certificate holder the conversion opportunity

described in paragraph (I)(1)(e)(3) of this rule; or

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

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

(f) Termination of a medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of medicare "Part D" benefits will not be considered in determining a continuous loss.

(g)

(i) A medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under "Title XIX of the Social Security Act," but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety days after the date the individual becomes entitled to assistance.

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

(iii) Each medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that

may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the "Social Security Act" and is covered under a group health plan as defined in section 1862 (b)(1)(A)(v) of the "Social Security Act." If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety days after the date of the loss.

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

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

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

(c) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(2) Standards for basic (core) benefits common to medicare supplement insurance benefit plans "A," "B," "C," "D," "F," "F With High Deductible," "G," "M," and "N". Every issuer of medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu of it.

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

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

(c) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred per cent of the medicare "Part A" eligible expenses for hospitalization paid at the

applicable prospective payment system ("PPS") rate, or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

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

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

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

(3) Standards for additional benefits. The following additional benefits shall be included in medicare supplement benefit plans "B," "C," "D," "F," "F With High Deductible," "G," "M," and "N" as provided by paragraph (K) of this rule.

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

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

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

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

(e) One hundred per cent of the medicare "Part B" excess charges: coverage for all of the difference between the actual medicare "Part B" charges as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved "Part B" charge.

(f) Medically necessary emergency care in a foreign country: coverage to the

extent not covered by medicare for eighty per cent of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by medicare if provided in the "United States" and which care began during the first sixty consecutive days of each trip outside the "United States," subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

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

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

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

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

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

(5) Make-up of benefit plans:

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

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

- (c) Standardized medicare supplement benefit plan "C" shall include only the following: the core benefit as defined in paragraph (H)(2) of this rule, plus the medicare "Part A" deductible, skilled nursing facility care, medicare "Part B" deductible and medically necessary emergency care in a foreign country as defined in paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(c), and (H)(3)(h) of this rule, respectively.
- (d) Standardized medicare supplement benefit plan "D" shall include only the following: the core benefit as defined in paragraph (H)(2) of this rule, plus the medicare "Part A" deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(h), and (H)(3)(i) of this rule, respectively.
- (e) Standardized medicare supplement benefit plan "E" shall include only the following: the core benefit as defined in paragraph (H)(2) of this rule, plus the medicare "Part A" deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(h), and (H)(3)(i) of this rule, respectively.
- (f) Standardized medicare supplement benefit plan "F" shall include only the following: the core benefit as defined in paragraph (H)(2) of this rule, plus the medicare "Part A" deductible, the skilled nursing facility care, the "Part B" deductible, one hundred per cent of the medicare "Part B" excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(c), (H)(3)(e), and (H)(3)(h) of this rule, respectively.
- (g) Standardized medicare supplement benefit high deductible plan "F" shall include only the following: one hundred per cent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in paragraph (H)(2) of this rule, plus the medicare "Part A" deductible, skilled nursing facility care, the medicare "Part B" deductible, one hundred per cent of the medicare "Part B" excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(c), (H)(3)(e) and (H)(3)(h) of this rule, respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible shall be fifteen hundred dollars for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the

consumer price index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

- (h) Standardized medicare supplement benefit plan "G" shall include only the following: the core benefit as defined in paragraph (H)(2) of this rule, plus the medicare "Part A" deductible, skilled nursing facility care, eighty per cent of the medicare "Part B" excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(d), (H)(3)(h), and (H)(3)(j) of this rule, respectively.
- (i) Standardized medicare supplement benefit plan "H" shall consist of only the following: the core benefit as defined in paragraph (H)(2) of this rule, plus the medicare "Part A" deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(f), and (H)(3)(h) of this rule, respectively. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.
- (j) Standardized medicare supplement benefit plan "I" shall consist of only the following: the core benefit as defined in paragraph (H)(2) of this rule, plus the medicare "Part A" deductible, skilled nursing facility care, one hundred per cent of the medicare "Part B" excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(e), (H)(3)(f), (H)(3)(h), and (H)(3)(j) of this rule, respectively. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.
- (k) Standardized medicare supplement benefit plan "J" shall consist of only the following: the core benefit as defined in paragraph (H)(2) of this rule, plus the medicare "Part A" deductible, skilled nursing facility care, medicare "Part B" deductible, one hundred per cent of the medicare "Part B" excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(c), (H)(3)(e), (H)(3)(g), (H)(3)(h), (H)(3)(i), and (H)(3)(j) of this rule, respectively. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.
- (l) Standardized medicare supplement benefit high deductible plan "J" shall consist of only the following: one hundred per cent of covered expenses

following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in paragraph (H)(2) of this rule, plus the medicare "Part A" deductible, skilled nursing facility care, medicare "Part B" deductible, one hundred per cent of the medicare "Part B" excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in paragraphs (H)(3)(a), (H)(3)(b), (H)(3)(c), (H)(3)(e), (H)(3)(g), (H)(3)(h), (H)(3)(i), and (H)(3)(j) of this rule, respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be fifteen hundred dollars for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the consumer price index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

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

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

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

(7) New or innovative benefits: an issuer may, with the prior approval of the superintendent, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

(K) Standard medicare supplement benefit plans for 2010 standardized medicare supplement benefit plan policies or certificates issued for delivery with an effective date for coverage on or after June 1, 2010.

The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for

coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to medicare supplement policies and certificates issued with an effective date for coverage before June 1, 2010 remain subject to the requirements of paragraph (J) of this rule.

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

(2) If an issuer makes available any of the additional benefits described in paragraph (I)(3) of this rule, or offers standardized benefit plans "K" or "L" as described in paragraph (K)(5)(h) and (K)(5)(i) of this rule, then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in the first sentence of paragraph (K) of this rule, a policy form or certificate form containing either standardized benefit plan "C" as described in paragraph (K)(5)(c) of this rule or standardized benefit plan "F" as described in (K)(5)(e) of this rule.

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

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

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

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

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

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

rule, plus one hundred per cent of the medicare "Part A" deductible as defined in paragraph (I)(3)(a) of this rule.

- (c) Standardized medicare supplement benefit plan "C" shall include only the following: the basic (core) benefit as defined in paragraph (I)(2) of this rule, plus one hundred per cent of the medicare "Part A" deductible, skilled nursing facility care, one hundred per cent of the medicare "Part B" deductible, and medically necessary emergency care in a foreign country as defined in paragraphs (I)(3)(a), (I)(3)(c), (I)(3)(d) and (I)(3)(f) of this rule, respectively.
- (d) Standardized medicare supplement benefit plan "D" shall include only the following: the basic (core) benefit (as defined in paragraph (I)(2) of this rule), plus one hundred per cent of the medicare "Part A" deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (I)(3)(a), (I)(3)(c) and (I)(3)(f) of this rule, respectively.
- (e) Standardized medicare supplement benefit plan "F" shall include only the following: the basic (core) benefit as defined in paragraph (I)(2) of this rule, plus one hundred per cent of the medicare "Part A" deductible, the skilled nursing facility care, one hundred per cent of the medicare "Part B" deductible, one hundred per cent of the medicare "Part B" excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (I)(3)(a), (I)(3)(c), (I)(3)(d), (I)(3)(e) and (I)(3)(f) of this rule, respectively.
- (f) Standardized medicare supplement plan "F With High Deductible" shall include only the following: one hundred per cent of covered expenses following the payment of the annual deductible set forth in subparagraph (K)(6)(f)(ii) of this rule.

 - (i) The basic (core) benefit as defined in paragraph (I)(2) of this rule, plus one hundred per cent of the medicare "Part A" deductible, skilled nursing facility care, one hundred per cent of the medicare "Part B" deductible, one hundred per cent of the medicare "Part B" excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (I)(3)(a), (I)(3)(c), (I)(3)(d), (I)(3)(e) and (I)(3)(f) of this rule, respectively.
 - (ii) The annual deductible in plan "F With High Deductible" shall consist of out-of-pocket expenses, other than premiums, for services covered by [regular] plan "F," and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be one thousand five hundred dollars, and shall be adjusted annually from 1999 by the secretary of the "United States"

department of health and human services to reflect the changes in the consumer price index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

- (g) Standardized medicare supplement benefit plan "G" shall include only the following: the basic (core) benefit as defined in paragraph (I)(2) of this rule, plus one hundred per cent of the medicare "Part A" deductible, skilled nursing facility care, one hundred per cent of the medicare "Part B" excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (I)(3)(a), (I)(3)(c), (I)(3)(e) and (I)(3)(f) of this rule, respectively.
- (h) Standardized medicare supplement plan "K" is mandated by the "Medicare Prescription Drug, Improvement and Modernization Act of 2003," and shall include only the following:

 - (i) "Part A" hospital coinsurance, sixty-first through ninetieth days: coverage of one hundred per cent of the "Part A" hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any medicare benefit period;
 - (ii) "Part A" hospital coinsurance, ninety-first through one hundred fiftieth days: coverage of one hundred per cent of the "Part A" hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any medicare benefit period;
 - (iii) "Part A" hospitalization after one hundred fifty days: upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred per cent of the medicare "Part A" eligible expenses for hospitalization paid at the applicable prospective payment system ("PPS") rate, or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;
 - (iv) Medicare "Part A" deductible: coverage for fifty per cent of the medicare "Part A" inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (K)(6)(h)(x) of this rule.
 - (v) Skilled nursing facility care: coverage for fifty per cent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a medicare benefit period for

post-hospital skilled nursing facility care eligible under medicare "Part A" until the out-of-pocket limitation is met as described in subparagraph (K)(6)(h)(x) of this rule.

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

(vii) Blood: coverage for fifty per cent, under medicare "Part A" or "B," of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph (K)(6)(h)(x) of this rule.

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

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

(x) Cost sharing after out-of-pocket limits: coverage of one hundred per cent of all cost sharing under medicare "Parts A" and "B" for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under medicare "Parts A" and "B" of four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the "United States" department of health and human services.

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

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

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

- (iii) The benefit described in subparagraph (K)(6)(h)(x) of this rule, but substituting two thousand dollars for four thousand dollars.
 - (j) Standardized medicare supplement plan "M" shall include only the following: the basic (core) benefit as defined in paragraph (I)(2) of this rule, plus fifty per cent of the medicare "Part A" deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in subparagraphs (I)(3)(b), (I)(3)(c) and (I)(3)(f) of this rule, respectively.
 - (k) Standardized medicare supplement plan "N" shall include only the following: the basic (core) benefit as defined in paragraph (I)(2) of this rule, plus one hundred per cent of the medicare "Part A" deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in subparagraphs (I)(3)(a), (I)(3)(c) and (I)(3)(f) of this rule, respectively, with copayments in the following amounts:
 - (i) The lesser of twenty dollars or the medicare "Part B" coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and
 - (ii) The lesser of fifty dollars or the medicare "Part B" coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a medicare "Part A" expense.
- (7) New or innovative benefits: an issuer may, with the prior approval of the superintendent, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to medicare supplement insurance, are new or innovative, are not otherwise available, and are cost effective. Approval of new or innovative benefits must not adversely impact the goal of medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.
- (L) Medicare select policies and certificates, as defined in this paragraph.
 - (1)
 - (a) This paragraph shall apply to medicare select policies and certificates, as defined in this paragraph.

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

(2) For the purposes of this paragraph:

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

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

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

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

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

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

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

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

(4) A medicare select issuer shall not issue a medicare select policy or certificate in this state until its plan of operation has been approved by the superintendent.

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

(a) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers.

including a demonstration that:

(i) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

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

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

(b) To make appropriate referrals.

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

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

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

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

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

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

(i) The formal organizational structure;

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

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

- (e) A list and description, by specialty, of the network providers.
 - (f) Copies of the written information proposed to be used by the issuer to comply with paragraph (L)(9) of this rule.
 - (g) Any other information requested by the superintendent.
- (6)
 - (a) A medicare select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the superintendent prior to implementing such changes. Such changes shall be considered approved by the superintendent after thirty days unless specifically disapproved.
 - (b) An updated list of network providers shall be filed with the superintendent at least quarterly.
- (7) A medicare select policy or certificate shall not restrict payment for covered services provided by non-network providers if:
 - (a) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and
 - (b) It is not reasonable to obtain such services through a network provider.
- (8) A medicare select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.
- (9) A medicare select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the medicare select policy or certificate to each applicant. This disclosure shall include at least the following:
 - (a) An outline of coverage as required by paragraph (S)(4)(c) of this rule, in the form prescribed in appendix "C".
 - (b) A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.
 - (c) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or

certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans "K" and "L".

- (d) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.
- (e) A description of limitations on referrals to restricted network providers and to other providers.
- (f) A description of the policyholder's right to purchase any other medicare supplement policy or certificate otherwise offered by the issuer.
- (g) A description of the medicare select issuer's quality assurance program and grievance procedure.
- (10) Prior to the sale of a medicare select policy or certificate, a medicare select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to paragraph (L)(9) of this rule and that the applicant understands the restrictions of the medicare select policy or certificate.
- (11) A medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

 - (a) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.
 - (b) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.
 - (c) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.
 - (d) If a grievance is found to be valid, corrective action shall be taken promptly.
 - (e) All concerned parties shall be notified about the results of a grievance.
 - (f) The issuer shall report no later than each March thirty-first to the superintendent regarding its grievance procedure. The report shall be in a format prescribed by the superintendent and shall contain the number of grievances filed in the past year and a summary of the subject, nature

and resolution of such grievances.

(12) At the time of initial purchase, a medicare select issuer shall make available to each applicant for a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate otherwise offered by the issuer.

(13)

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

(b) For the purposes of paragraph (L)(13) of this rule, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the medicare "Part A" deductible, coverage for at-home recovery services or coverage for "Part B" excess charges.

(14) Medicare select policies and certificates shall provide for continuation of coverage in the event the secretary of health and human services determines that medicare select policies and certificates issued pursuant to this paragraph should be discontinued due to either the failure of the medicare select program to be reauthorized under law or its substantial amendment.

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

(b) For the purposes of paragraph (L)(14) of this rule, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the medicare "Part A" deductible, coverage for at-home recovery services

or coverage for "Part B" excess charges.

- (15) A medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the "United States" department of health and human services, for the purpose of evaluating the medicare select program.

(M) Open enrollment

- (1) An issuer shall not deny or condition the issuance or effectiveness of any medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six month period beginning with the first day of the first month in which an individual is both sixty-five years of age or older and is enrolled for benefits under medicare "Part B". Each medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under paragraph (M)(1) of this rule without regard to age.

(2)

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

- (b) If the applicant qualifies under paragraph (M)(1) of this rule and submits an application during the time period referenced in paragraph (M)(1) of this rule and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this paragraph.

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

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

issuer shall:

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

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

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

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

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

(N) Guaranteed issue for eligible persons

(1) Guaranteed issue

(a) Eligible persons are those individuals described in paragraph (N)(2) of this rule who seek to enroll under the policy during the period specified in paragraph (N)(3) of this rule and who submit evidence of the date of termination, disenrollment, or medicare "Part D" enrollment with the application for a medicare supplement policy.

(b) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a medicare supplement policy described in paragraph (N)(5) of this rule that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a medicare supplement policy.

(2) Eligible persons

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

(a) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan;

(b)

(i) The individual is enrolled with a "Medicare Advantage" organization under a "Medicare Advantage" plan under "Part C" of medicare, and any of the following circumstances apply, or the individual is sixty-five years of age or older and is enrolled with a "Program of All-Inclusive Care for the Elderly (PACE)" provider under section 1894 of the "Social Security Act", and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a "Medicare Advantage" plan:

(a) The certification of the organization or plan under this part has been terminated; or

(b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal "Social Security Act" (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

(d) The individual demonstrates, in accordance with guidelines established by the secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's contract

under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(e) The individual meets such other exceptional conditions as the secretary may provide.

(c)

(i) The individual is enrolled with:

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

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

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

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

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

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

(i)

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

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

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

of the policy; or

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

(e)

(i) The individual was enrolled under a medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any "Medicare Advantage" organization under a "Medicare Advantage" plan under "Part C" of medicare, any eligible organization under a contract under section 1876 (medicare risk or cost), any similar organization operating under demonstration project authority, any "PACE" program under section 1894 of the "Social Security Act", or a medicare select policy; and

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

(f) The individual, upon first becoming eligible for medicare "Part A" for benefits at age sixty-five or older, enrolls in a "Medicare Advantage" plan under "Part C" of medicare, or with a "PACE" provider under section 1894 of the "Social Security Act," and disenrolls from the plan or program by not later than twelve months after the effective date of enrollment.

(g) The individual enrolls in a medicare "Part D" plan during the initial enrollment period and, at the time of enrollment in "Part D", was enrolled under a medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the medicare supplement policy and submits evidence of enrollment in medicare "Part D" along with the application for a policy described in paragraph (N)(5)(d) of this rule.

(3) Guaranteed issue time periods

(a) In the case of an individual described in paragraph (N)(2)(a) of this rule, the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three days thereafter;

- (b) In the case of an individual described in paragraph (N)(2)(b), (N)(2)(c), (N)(2)(e), or (N)(2)(f) of this rule whose enrollment terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three days after the date the applicable coverage is terminated;
- (c) In the case of an individual described in paragraph (N)(2)(d)(i) of this rule, the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three days after the date the coverage is terminated;
- (d) In the case of an individual described in paragraph (N)(2)(b), (N)(2)(d)(ii), (N)(2)(d)(iii), (N)(2)(e) or (N)(2)(f) of this rule, who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty days before the effective date of the disenrollment and ends on the date that is sixty-three days after the effective date;
- (e) In the case of an individual described in paragraph (N)(2)(g) of this rule, the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the "Social Security Act" from the medicare supplement issuer during the sixty-day period immediately preceding the initial "Part D" enrollment period and ends on the date that is sixty-three days after the effective date of the individual's coverage under medicare "Part D"; and
- (f) In the case of an individual described in paragraph (N)(2) of this rule but not described in the preceding provisions of this paragraph, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three days after the effective date.

(4) Extended medigap access for interrupted trial periods

- (a) In the case of an individual described in paragraph (N)(2)(e) of this rule (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in paragraph (N)(2)(e)(i) of this rule is involuntarily terminated within the first twelve months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (N)(2)(e) of this rule;
- (b) In the case of an individual described in paragraph (N)(2)(f) of this rule, (or deemed to be so described, pursuant to this paragraph) whose

enrollment with a plan or in a program described in paragraph (N)(2)(f) of this rule is involuntarily terminated within the first twelve months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (N)(2)(f) of this rule; and

- (c) For the purposes of paragraphs (N)(2)(e) and (N)(2)(f) of this rule, no enrollment of an individual with an organization or provider described in paragraph (N)(2)(e)(i) of this rule, or with a plan or in a program described in paragraph (N)(2)(f) of this rule, may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

(5) Products to which eligible persons are entitled

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

- (a) Paragraphs (N)(2)(a), (N)(2)(b), (N)(2)(c) and (N)(2)(d) of this rule is a medicare supplement policy which has a benefit package classified as plan "A," "B," "C," "F" (including "F" with a high deductible), "K" or "L" offered by any issuer.

(b)

- (i) Subject to paragraph (N)(5)(b)(ii) of this rule, paragraph (N)(2)(e) of this rule is the same medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph (N)(5)(a) of this rule;

- (ii) After December 31, 2005, if the individual was most recently enrolled in a medicare supplement policy with an outpatient prescription drug benefit, a medicare supplement policy described in this subparagraph is:

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

(b) At the election of the policyholder, an "A," "B," "C," "F" (including "F" with a high deductible), "K" or "L" policy that is offered by any issuer;

- (c) Section (N)(2)(f) of this rule shall include any medicare supplement policy offered by any issuer;

(d) Paragraph (N)(2)(g) of this rule is a medicare supplement policy that has a benefit package classified as Plan "A," "B," "C," "F" (including "F" with a high deductible), "K" or "L", and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's medicare supplement policy with outpatient prescription drug coverage.

(6) Notification provisions

(a) At the time of an event described in paragraph (N)(2) of this rule because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under paragraph (N) of this rule, and of the obligations of issuers of medicare supplement policies under paragraph (N)(1) of this rule. Such notice shall be communicated contemporaneously with the notification of termination.

(b) At the time of an event described in paragraph (N)(2) of this rule because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under paragraph (N) of this rule, and of the obligations of issuers of medicare supplement policies under paragraph (N)(1) of this rule. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

(O) Standards for claims payment

(1) An issuer shall comply with section 1882(C)(3) of the "Social Security Act" (as enacted by section 4081 (B)(2)(C) of the "Omnibus Budget Reconciliation Act of 1987" (OBRA '87), Pub. L. No. 100-203) by:

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

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

(c) Paying the participating physician or supplier directly;

- (d) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a medicare carrier may be sent;
- (e) Paying user fees for claim notices that are transmitted electronically or otherwise; and
- (f) Providing to the secretary of health and human services, at least annually, a central mailing address to which all claims may be sent by medicare carriers.

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

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

(1) Loss ratio standards

(a)

(i) A medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

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

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

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

(a) Home office and overhead costs;

(b) Advertising costs;

(c) Commissions and other acquisition costs;

(d) Taxes;

(e) Capital costs;

(f) Administrative costs; and

(g) Claims processing costs.

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

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

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

(ii) The appropriate loss ratio requirement from paragraphs (P)(1)(a)(i)(a) and (P)(1)(a)(i)(b) of this rule when combined with actual experience beginning with the effective date of this rule revision to date; and

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

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

(2) Refund or credit calculation

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

- (b) If on the basis of the experience as reported, the benchmark ratio since inception (ratio one) exceeds the adjusted experience ratio since inception (ratio three), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.
- (c) For the purposes of this paragraph, policies or certificates issued prior to May 1, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after the effective date of this amendment. The first such report shall be due by May 31, 1998.
- (d) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but in no event shall it be less than the average rate of interest for thirteen-week treasury notes. A refund or credit against premiums due shall be made by September thirtieth following the experience year upon which the refund or credit is based.

(3) Annual filing of premium rates

- (a) An issuer of medicare supplement policies and certificates issued before or after the effective date of this rule in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the superintendent in accordance with the filing requirements and procedures prescribed by the superintendent. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.
- (b) As soon as practicable, but prior to the effective date of enhancements in medicare benefits, every issuer of medicare supplement policies or certificates in this state shall file with the superintendent in accordance with the applicable filing procedures of this state:

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

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

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

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

(4) Public hearings

The superintendent may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this rule if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the superintendent.

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

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

(2) An issuer shall file any riders or amendments to policy or certificate forms to

delete outpatient prescription drug benefits as required by the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003" only with the superintendent in the state in which the policy or certificate was issued.

- (3) An issuer shall not use or change premium rates for a medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the superintendent in accordance with the filing requirements and procedures prescribed by the superintendent. The superintendent shall use the following process for approving or disapproving proposed premium increases:
- (a) As used in this paragraph, "benefits provided are not unreasonable in relation to the premium charged" means that the rates were calculated in accordance with sound actuarial principles.
- (b) With respect to any filing of any premium rates for any individual or group medicare supplement policy, or for any endorsement or rider pertaining thereto, the superintendent of insurance may, within thirty days after filing:
- (i) Disapprove such filing if he finds that the benefits provided are unreasonable in relation to the premium charged. Such disapproval shall be effected by written order of the superintendent, a copy of which shall be mailed to the issuer that has made the filing. In the order, the superintendent shall specify the reasons for his disapproval and state that a hearing will be held within fifteen days after requested in writing by the issuer. If a hearing is so requested, the superintendent shall also give such public notice as he considers appropriate. The superintendent, within fifteen days after the commencement of any hearing, shall issue a written order, a copy of which shall be mailed to the issuer that has made the filing, either affirming his prior disapproval or approving such filing if he finds that the benefits provided are not unreasonable in relation to the premium charged.
- (ii) Set a date for a public hearing to commence no later than forty days after the filing. The superintendent shall give the issuer making the filing twenty days' written notice of the hearing and shall give such public notice as he considers appropriate. The superintendent, within twenty days after the commencement of a hearing, shall issue a written order, a copy of which shall be mailed to the issuer that has made the filing, either approving such filing if he finds that the benefits provided are not unreasonable in relation to the premium charged, or disapproving such filing if he finds that the benefits provided are unreasonable in relation to the premium charged.

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

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

(d) The superintendent may retain at the issuer's expense such attorneys, actuaries, accountants, and other experts not otherwise a part of the superintendent's staff as shall be reasonably necessary to assist in the preparation for and conduct of any public hearing under this section. The expense for retaining such experts and the expenses of the department of insurance incurred in connection with such public hearing shall be assessed against the issuer in an amount not to exceed one one-hundredth of one per cent of the sum of premiums earned plus net realized investments gain or loss of such issuer as reflected in the most current annual statement on file with the superintendent. Any person retained shall be under the direction and control of the superintendent and shall act in a purely advisory capacity.

(4)

(a) Except as provided in paragraph (Q)(4)(b) of this rule, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard medicare supplement benefit plan.

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

(i) The inclusion of new or innovative benefits;

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

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

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

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

(5)

(a) Except as provided in paragraph (Q)(5)(a)(i) of this rule, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this rule that has been approved by the superintendent. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months.

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

(ii) An issuer that discontinues the availability of a policy form or certificate form pursuant to paragraph (Q)(5)(a)(i) of this rule shall not file for approval a new policy form or certificate form of the same type for the same standard medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the superintendent of the discontinuance. The period of discontinuance may be reduced if the superintendent determines that a shorter period is appropriate.

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

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

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

(ii) The issuer does not subsequently put into effect a change of rates or

rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The superintendent may approve a change to the differential which is in the public interest.

(6)

(a) Except as provided in paragraph (Q)(6)(b) of this rule, the experience of all policy forms or certificate forms of the same type in a standard medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in paragraph (P) of this rule.

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

(R) Permitted compensation arrangements

(1) An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred per cent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

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

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

(4) For purposes of paragraphs (M) and (R) of this rule, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

(5) No issuer or other entity shall violate the provisions of paragraph (M)(3) of this rule.

(S) Required disclosure provisions

(1) General rules.

(a) Medicare supplement policies and certificates shall include a renewal or

continuation provision. The language or specifications of such provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the age of the policyholder or certificate holder.

- (b) All riders or endorsements added to a medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured, except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a medicare supplement policy other than the right to reduce or eliminate benefits or coverage, or is required to reduce or eliminate benefits to avoid duplication of medicare benefits. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.
- (c) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.
- (d) If a medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "preexisting condition limitations."
- (e) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.
- (f)

 - (i) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person(s) eligible for medicare

shall provide to those applicants a "Guide to Health Insurance for People with Medicare" in the form developed jointly by the "National Association of Insurance Commissioners" and the "Centers for Medicare and Medicaid Services" ("CMS") and in a type size no smaller than twelve point type. Delivery of the guide shall be made whether or not such policies or certificates are advertised, solicited or issued as medicare supplement policies or certificates as defined in this rule. Except in the case of direct response issuers, delivery of the guide shall be made to the applicant at the time of application and acknowledgement of receipt of the guide shall be obtained by the issuer. Direct response issuers shall deliver the guide to the applicant upon request but not later than at the time the policy is delivered.

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

(2) Notice requirements.

(a) As soon as practicable, but no later than thirty days prior to the annual effective date of any medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to medicare supplement policies or certificates in a format acceptable to the superintendent. The requirements of this paragraph apply to medicare supplement policies and certificates delivered or issued for delivery in this state before or after the effective date of this rule. The notice shall be in twelve point type in a format acceptable to the superintendent. The notice shall:

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

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

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

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

(3) "MMA" notice requirements.

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

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

(a) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant; and

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

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

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

(Include for each plan prominently identified in the cover page, a chart showing the services, medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, layout, and format as shown in the charts in appendix "C" to this rule. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in appendix "C" to this rule. An issuer may use additional benefit plan designations on these charts pursuant to paragraph (J)(4) and (K)(5) of this rule as applicable.)

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

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

(a) Any sickness and accident insurance policy or certificate, other than a medicare supplement policy or a policy issued pursuant to a contract under section 1876 of the federal "Social Security Act" (42 U.S.C. section 1395, et seq.); disability income policy; or other policy identified in paragraph (C)(2) of this rule, issued for delivery in this state to persons eligible for medicare shall notify insureds under the policy that the policy is not a medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve-point type and shall contain the following language:

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

(b) Applications provided to persons eligible for medicare for the health insurance policies or certificates described in paragraph (S)(4)(a) of this rule shall disclose, using the applicable statement in appendix "F", the extent to which the policy duplicates medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

(T) Requirements for application forms and replacement coverage

(1) Application forms shall include the statements and questions in appendix "D" to this rule designed to elicit information as to whether, as of the date of the application, the applicant currently has medicare supplement, "Medicare Advantage", medicaid coverage, or another health insurance policy or certificate in force or whether a medicare supplement policy or certificate is intended to replace any other sickness and accident policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, containing such statements and questions may be used.

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

(3) Upon determining that a sale will involve replacement of medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall

furnish the applicant, prior to issuance or delivery of the medicare supplement policy or certificate, a notice regarding replacement of medicare supplement coverage. One copy of such notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of medicare supplement coverage.

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

(U) Filing requirements for advertising

- (1) Each issuer of medicare supplement policies or certificates in this state shall provide to the superintendent, prior to its use, a copy of any medicare supplement advertisement intended for use in this state, whether through written or electronic media. No such advertisement shall be used unless approved in writing by the superintendent. Any advertisement not disapproved within thirty days after filing shall be deemed approved.
- (2) If the image or voice of a celebrity is used in the advertisement, any medicare supplement advertisement shall disclose that the celebrity has been paid to endorse or advertise the policy.

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

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

(V) Standards for marketing

- (1) An issuer, directly or through its producers, shall:
- (a) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.
 - (b) Establish marketing procedures to assure excessive insurance is not sold or issued.
 - (c) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

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

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

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

(2) In addition to the practices prohibited in sections 3901.19 through 3901.221 of the Revised Code, paragraph (C) of rule 3901-1-07 of the Administrative Code, and paragraph (D) of rule 3901-1-35 of the Administrative Code, the following acts and practices are prohibited:

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

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

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

(3) The terms "medicare supplement," "medigap," "medicare wrap-around" and words of similar import shall not be used unless the policy is issued in compliance with this rule.

(W) Appropriateness of recommended purchase and excessive insurance

(1) In recommending the purchase or replacement of any medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

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

- (3) An issuer shall not issue a medicare supplement policy or certificate to an individual enrolled in medicare "Part C" unless the effective date of the coverage is after the termination date of the individual's "Part C" coverage.

(X) Reporting of multiple policies

- (1) On or before March first of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one medicare supplement policy or certificate:

(a) Policy and certificate number, and

(b) Date of issuance.

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

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

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

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

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

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

- (1) An issuer of a medicare supplement policy or certificate shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a preexisting condition) and shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

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

- (a) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for an employer based on the manifestation of a disease or disorder of an insured or applicant; or
 - (b) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group.)
- (3) An issuer of a medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.
- (4) Subparagraph (Z)(3) of this rule shall not be construed to preclude an issuer of a medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part "C" of "Title XI" and section 264 of the "Health Insurance Portability and Accountability Act of 1996," as may be revised from time to time) and consistent with subparagraph (Z)(1).
- (5) For purposes of carrying out subparagraph (Z)(4) of this rule, an issuer of a medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.
- (6) Notwithstanding subparagraph (Z)(3) of this rule, an issuer of a medicare supplement policy may request, but not require, that an individual or a family member of such an individual undergo a genetic test if each of the following conditions is met:
 - (a) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.
 - (b) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made, that:
 - (i) Compliance with the test is voluntary; and
 - (ii) Non-compliance will have no effect on enrollment status or premium or contribution amounts.

- (c) No genetic information collected or acquired under this subparagraph (Z)(6) of this rule shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.
- (d) The issuer notifies the secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subparagraph (Z)(6) of this rule, including a description of the activities conducted.
- (e) The issuer complies with such other conditions as the secretary may by regulation require for activities conducted under this subparagraph (Z)(6) of this rule.
- (7) An issuer of a medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.
- (8) An issuer of a medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.
- (9) If an issuer of a medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of subparagraph (Z)(8) of this rule if such request, requirement, or purchase is not in violation of subparagraph (Z)(7) of this rule.
- (10) For the purposes of this paragraph (Z) of this rule:

 - (a) "Issuer of a medicare supplement policy or certificate" includes a third-party administrator, or other person acting for or on behalf of such issuer.
 - (b) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.
 - (c) "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

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

(e) "Genetic test" means an analysis of human "DNA," "RNA," chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(f) "Underwriting purposes" means:

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

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

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

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

(AA) Severability

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

Replaces: 3901-1-41

Effective:

R.C. 119.032 review dates:

Certification

Date

Promulgated Under: 119.03
Statutory Authority: 3901.041, 3923.33, 3923.331 to 3923.339
Rule Amplifies: 3923.33, 3923.331 to 3923.339
Prior Effective Dates: 6/4/1982, 2/10/1989 (Emer.), 7/24/1989 (Emer.),
11/10/1989, 12/28/1989 (Emer.), 10/19/1990,
5/1/1992, 4/26/1996, 11/19/1998 (Emer.), 1/14/1999,
8/1/2001, 11/14/2002, 8/4/2005