Volume 30, Number 12
Pages 1215–1428
June 15, 2005

SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

ROBIN CARNAHAN
SECRETARY OF STATE

MISSOURI REGISTER

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The *Missouri Register* is published semi-monthly by

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ISSN 0149-2942, USPS 320-630; periodical postage paid at Jefferson City, MO
Subscription fee: $56.00 per year

POSTMASTER: Send change of address notices and undelivered copies to:

MISSOURI REGISTER
Office of the Secretary of State
Administrative Rules Division
PO Box 1767
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Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at http://www.sos.mo.gov/adrules/pubsched.asp

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The rules are codified in the *Code of State Regulations* in this system—

Title	*Code of State Regulations*	Division	Chapter	Rule
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—The most recent version of the statute containing the section number and the date.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons and findings which support its conclusion that there is an immediate danger to the public health, safety or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title 20—DEPARTMENT OF INSURANCE
Division 400—Life, Annuities and Health
Chapter 3—Medicare Supplement Insurance

EMERGENCY AMENDMENT

20 CSR 400-3.650 Medicare Supplement Insurance Minimum Standards Act. The department is amending sections (1)–(10), (12)–(16), (18) and (19) of this rule. The department is deleting section (23) of this rule. This amendment also replaces a portion of the form referred to in paragraph (15)(C)4., which is found on pages 59–60 of 20 CSR 400-3 as published in the *Code of State Regulations*.

PURPOSE: This amendment changes the terms "agent" and "broker" to "insurance producer," and also implements changes necessary to remain consistent with minimum federal standards applicable to Medicare Supplement Insurance.

EMERGENCY STATEMENT: This emergency amendment is necessary to preserve the public welfare of Missouri citizens by ensuring the Missouri Department of Insurance has adequate time, before the effective date of federal legislation on January 1, 2006, to review and approve insurers' Medicare supplement insurance filings that will provide coverage for eligible Missouri residents. As a result, the Missouri Department of Insurance finds an immediate danger to the public welfare and a compelling governmental interest, which requires emergency action. The scope of this emergency amendment is limited to the conditions creating the emergency and complies with the protections extended in the ***Missouri and United States Constitutions****. In developing this emergency amendment, representatives of the insurance industry were consulted. The department believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed May 16, 2005, effective June 1, 2005, expires February 2, 2006.*

(1) Applicability and Scope.

(C) All forms printed with this rule are included herein.

(2) Definitions. For purposes of this rule—

(B) "Bankruptcy" means when a Medicare*[+Choice]***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;

(J) "Insurance producer" means a person required to be licensed under section 375.012(6), *Revised Statutes of Missouri*, to sell, solicit or negotiate insurance;

*[(J)]***(K)** "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates;

*[(K)]***(L)** "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended;

*[(L)]***(M)** "Medicare*[+Choice]***Advantage** plan" means a plan of coverage for health benefits under Medicare Part C as defined in section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33, and includes:

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

2. Medical savings account plans coupled with a contribution into a Medicare*[+Choice]***Advantage** medical savings account; and

3. Medicare*[+Choice]***Advantage** private fee-for-service plans;

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

*[(N)]***(O)** "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer;

*[(O)]***(P)** "Pre-standardized Medicare supplement plan" means a Medicare supplement plan issued prior to July 30, 1992;

*[(P)]***(Q)** "Qualified actuary" means a member of the American Academy of Actuaries;

*[(Q)]***(R)** "Standardized Medicare Supplement Plan" means a Medicare supplement plan issued after July 30, 1992; and

*[(R)]***(S)** "Secretary" means the Secretary of the United States Department of Health and Human Services.

(3) Policy Definitions and Terms. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare

supplement policy or certificate unless the policy or certificate contains definitions or terms which conform to the requirements of this section.

(D) "Health care expenses" means**, for purposes of section (12),** expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. *[Expenses shall not include:*

1. Home office and overhead costs;

2. Advertising costs;

3. Commissions and other acquisition costs;

4. Taxes;

5. Capital costs;

6. Administrative costs; and

7. Claims processing costs.]

(G) "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.

(4) Policy Provisions.

(D)

1. Subject to paragraphs (5)(A)4., 5. and 7. and (6)(A)4. and 5., 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.

2. A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

3. 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:

A. 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;

B. 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.

(5) Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to July 30, 1992. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

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

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

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

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

4. A "noncancelable," "guaranteed renewable," or "noncancelable and guaranteed renewable" Medicare supplement policy shall not—

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

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

5.

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

B. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subparagraph D. of this paragraph, the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

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

(II) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in subsection (6)(B) of this rule.

C. If membership in a group is terminated, the issuer shall—

(I) Offer the certificate holder the conversion opportunities described in subparagraph 5.B. of this subsection; or

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

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

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

7. 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.

(6) Benefit Standards for Policies or Certificates Issued or Delivered on or After July 30, 1992. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 30, 1992. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

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

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

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

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

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

5. Each Medicare supplement policy shall be guaranteed renewable.

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

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

C. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph (6)(A)5.E., the issuer shall offer certificate holders an individual Medicare supplement policy which at the option of the certificate holder:

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

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

D. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall—

(I) Offer the certificate holder the conversion opportunity described in subparagraph (6)(A)5.C.; or

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

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

F. 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.

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

7.

A. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period not to exceed twenty-four (24) 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 (90) days after the date the individual becomes entitled to assistance.

B. 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 if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

C. 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 rule) 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 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 (90) days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

*[C.]***D.** Reinstitution of coverages*[—]***as described in subparagraphs (6)(A)7.B. and (6)(A)7.C:**

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

(II) Shall provide for **resumption of** coverage which is substantially equivalent to coverage in effect before the date of suspension*[;]***. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution 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

(III) 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.

(B) Standards for Basic (Core) Benefits Common to *[All Benefit Plans]* **Benefit Plans A–J**. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period.

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

3. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of **one hundred percent (100%) of** the Medicare Part A eligible expenses for hospitalization paid at the *[diagnostic related group (DRG) day outlier per diem]* **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 (365) days. **The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.**

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

5. Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(C) Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by section (7) of this rule.

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

2. Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day

through the hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

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

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

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

6. Basic Outpatient Prescription Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar*[s]* ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare. **The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.**

7. Extended Outpatient Prescription Drug Benefit*[:]***.** Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar*[s]* ($250) calendar year deductible to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. **The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.**

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

9. Preventive Medical Care Benefit. Coverage for the following preventive health services*[:]* **not covered by Medicare:**

A. An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph B. and patient education to address preventive health care measures;

[B. Any one (1) or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(I) Fecal occult blood test or digital rectal examination, or both;

(II) Mammogram;

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

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

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

(VI) Thyroid function test;

(VII) Diabetes screening;]

B. Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician;

C. Influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster as medically appropriate; **and**

[D. Any other tests or preventive measures determined appropriate by the attending physician; and]

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

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

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

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

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

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

(IV) "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four (24)-hour period of services provided by a care provider is one (1) visit.

B. Coverage Requirements and Limitations.

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

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

(III) Coverage is limited to—

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

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

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

(d) Seven (7) visits in any one (1) week;

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

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

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

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

C. Coverage is excluded for—

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

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

11. New or Innovative Benefits. An issuer may, with the prior approval of the director, 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.**

(D) Standards for Plans K and L.

1. Standardized Medicare supplement benefit plan "K" shall consist of the following:

A. Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

B. Coverage of one hundred percent (100%) 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;

C. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) 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 (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

D. Medicare Part A deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (6)(D)1.J.;

E. Skilled nursing facility care: Coverage for fifty percent (50%) 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 (6)(D)1.J.;

F. Hospice care: Coverage for fifty percent (50%) 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 (6)(D)1.J.;

G. Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal rules) unless replaced in accordance with federal rules until the out-of-pocket limitation is met as described in subparagraph (6)(D)1.J.;

H. Except for coverage provided in subparagraph (6)(D)1.I. below, coverage for fifty percent (50%) 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 (6)(D)1.J. below;

I. Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

J. Coverage of one hundred percent (100%) 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 ($4,000) in 2006, indexed each year by the appropriate inflation adjustments specified by the secretary of the U.S. Department of Health and Human Services.

2. Standardized Medicare supplement benefit plan "L" shall consist of the following:

A. The benefits described in subparagraphs (6)(D)1.A., B., C., and I.;

B. The benefit described in subparagraphs (6)(D)1.D., E., F., G., and H., but substituting seventy-five percent (75%) for fifty percent (50%); and

C. The benefit described in subparagraph (6)(D)1.J., but substituting two thousand dollars ($2,000) for four thousand dollars ($4,000).

(7) Standard Medicare Supplement Benefit Plans.

(A) 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 subsections (6)(B) **and (6)(C)** of this rule.

(C) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through *["J"]* **"L"** listed in this section and conform to the definitions in section (3) of this rule. Each benefit shall be structured in accordance with the format provided in subsections (6)(B)*[and]***,** (6)(C)**, and (6)(D)** and list the benefits in the order shown in this section. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

(E) Make-Up of Benefit Plans.

1. Standardized Medicare supplement benefit plan "A" shall be limited to the basic (core) benefits common to all benefit plans, as defined in subsection (6)(B) of this rule.

2. Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible as defined in paragraph (6)(C)1.

3. Standardized Medicare supplement benefit plan "C" shall include only the following: The core benefit as defined in subsection (6)(B) 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 (6)(C)1., 2., 3. and 8. respectively.

4. Standardized Medicare supplement benefit plan "D" shall include only the following: The core benefit (as defined in subsection (6)(B) of this rule), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in foreign country and the at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 8. and 10. respectively.

5. Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefit as defined in subsection (6)(B) 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 (6)(C)1., 2., 8. and 9. respectively.

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

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

deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible shall be one thousand five hundred dollars ($1,500) 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 (12)-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

8. Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 4., 8. and 10. respectively.

9. Standardized Medicare supplement benefit plan "H" shall consist of only the following: The core benefit as defined in subsection (6)(B) 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 (6)(C)1., 2., 6. and 8. respectively. **The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.**

10. Standardized Medicare supplement benefit plan "I" shall consist of only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in paragraphs (6)*[(B)]***(C)**1., 2., 5., 6., 8. and 10. respectively. **The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.**

11. Standardized Medicare supplement benefit plan "J" shall consist of only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 3., 5., 7., 8., 9. and 10. respectively. **The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.**

12. Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: one hundred percent (100%) of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in subsection (6)(B) of this rule, plus the Medicare part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 3., 5., 7., 8., 9. and 10. respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be fifteen hundred dollars ($1,500) 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 (12)-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10). **The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.**

(F) Make-up of two (2) Medicare supplement plans mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

1. Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in paragraph (6)(D)1.

2. Standardized Medicare supplement plan "L" shall consist only of those benefits described in paragraph (6)(D)2.

(8) Medicare Select Policies and Certificates. This section shall apply to Medicare Select policies and certificates, as defined in this section.

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

1. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with—

A. Other Medicare supplement policies or certificates offered by the issuer; and

B. Other Medicare Select policies or certificates;

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

3. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized*[;]***. 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";**

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

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

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

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

(M)

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

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

(N) Medicare Select policies and certificates shall provide for continuation of coverage in the event the secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

1. Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the

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

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

(9) Open Enrollment.

(A) No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6)-month period beginning with the first day of the first month in which the applicant is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B.

1. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

(E) No issuer required by subsection (B) of this section to issue policies or certificates of Medicare supplement insurance shall discriminate as to rates, between the rates charged to persons enrolled under subsection (B) of this section and the average rates charged for participation in that policy form number or certificate form number by persons enrolled in Medicare Part B by reason of age, or discriminate between persons entitled to enroll in the policy form number or certificate form number under subsection (B) of this section and other enrollees in the policy form number or certificate form number in other terms or conditions of the plan, policy form number, or certificate form number.

1. An issuer must demonstrate compliance with this section for each plan, type, and form level permitted under subsection (13)*[(C)]***(D)** by either—

A. Charging a premium rate for disabled persons that does not exceed the lowest available aged premium rate for that plan, type, and form level; or

B. Charging a premium rate for disabled persons that does not exceed the "weighted average aged premium rate" for that plan, type, and form level, and providing, at the time of each rate filing, its calculation of the "weighted average aged premium rate" for each plan, type, and form level.

2. The "weighted average aged premium rate" is determined by—

A. First multiplying the premium rate (calculated prior to modal, area, and other factors) for each age band, age sixty-five (65) and over, by the number of Missouri insureds in-force in that age band to arrive at the total Missouri premium for each age band age sixty-five (65) and over; and

B. Then calculating the sum of the Missouri premium for all age bands age sixty-five (65) and over to arrive at the total Missouri premium for all age bands age sixty-five (65) and over; and

C. Then calculating the sum of the Missouri insureds*[-]*in-force for all age bands age sixty-five (65) and over to arrive at the total number of Missouri insureds in-force for all age bands age sixty-five (65) and over; and

D. Then dividing the total Missouri premium for all age bands age sixty-five (65) and over by the total number of Missouri insureds in-force for all age bands, age sixty-five (65) and over to determine the weighted average aged premium rate.

3. Modal, area, and other factors may be added to the disabled premium.

(H) No Medicare supplement carrier shall, directly or indirectly enter into any contract, agreement or arrangement with an *[agent or broker]* **insurance producer** that provides for or results in the compensation paid to an *[agent or broker]* **insurance producer** for the sale of a Medicare supplement policy or certificate to be varied because of the age, health status, claims experience, receipt of health care or medical condition of an applicant eligible by reason of subsection (B) of this section for Medicare supplement insurance.

(I) A Medicare supplement carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an *[agent or broker]* **insurance producer**, if any, for the sale, during the open enrollment periods described in subsection (B) of this section, of a Medicare supplement insurance policy or certificate.

(J) No Medicare supplement insurance carrier shall terminate, fail to renew or limit its contract or agreement of representation with an *[agent or broker]* **insurance producer** for any reason related to the age, health status, claims experience, receipt of health care or medical condition of an applicant, eligible by reason of subsection (B) of this section for Medicare supplement insurance, placed by the *[agent or broker]* **insurance producer** with the Medicare supplement insurance carrier.

(10) Guaranteed Issue for Eligible Persons.

(A) Guaranteed Issue.

1. Eligible persons are those individuals described in subsection (B) of this section who *[apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in subsection (B) of this section,]* **seek to enroll under the policy during the period specified in subsection (C) of this section,** and who submit evidence*[, acceptable to the director,]* of the date of termination *[or disenrollment]***, disenrollment, or Medicare Part D enrollment** with the application for a Medicare supplement policy.

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

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

1. The individual is enrolled under an employee welfare benefit plan **that provides health benefits that supplement the benefits under Medicare**; and the plan terminates, or the plan ceases to provide *[substantial health benefits to the individual either because the plan is modified or amended, or because the plan terminates, or because the individual leaves the plan]* **all such supplemental health benefits to the individual**;

2. The individual is enrolled with a Medicare*[+Choice]* **Advantage** organization under a Medicare*[+Choice]***Advantage** plan under Part C of Medicare, and any of the following circumstances apply, **or the individual is sixty-five (65) 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 organization's or plan's certification has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

B. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or because the plan is terminated for all individuals within a residence area or because of another 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);

C. 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]* **insurance producer**, or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

D. The individual meets such other exceptional conditions as the secretary may provide;

3.

A. The individual is enrolled with—

(I) An eligible organization under a contract under section 1876 (Medicare risk or cost);

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

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

(IV) An organization under a Medicare Select Policy; and

B. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (10)(B)2.;

4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because—

A.

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

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

B. The issuer of the policy substantially violated a material provision of the policy; or

C. The issuer, *[or an agent]* **insurance producer,** or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

5.

A. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare*[+Choice]***Advantage** organization under a Medicare*[+Choice]***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 provider under section 1894 of the Social Security Act,** an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan), or a Medicare Select policy; and

B. The subsequent enrollment under subparagraph (10)(B)5.A. is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

6. The individual, upon first becoming eligible for benefits under Part A of Medicare *[and enrolling in Medicare Part B]*, enrolls in a Medicare*[+Choice]***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 (12) months after the effective date of enrollment; and

7. 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 (E)4. of this section; and

*[7.]***8.** Any individual who terminates Medicare supplement coverage within thirty (30) days of the annual policy anniversary.

(C) Guarantee Issue Time Periods.

1. In the case of an individual described in paragraph (B)1. of this section, 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 (63) days thereafter;

2. In the case of an individual described in paragraph (B)2., (B)3., (B)5. or (B)6. of this section whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage was terminated;

3. In the case of an individual described in subparagraph (B)4.A., of this section the guarantee issue period begins on the earlier of: (i) the date that 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 (63) days after the date the coverage was terminated;

4. In the case of an individual described in paragraph (B)2., subparagraph (B)4.B., (B)4.C., paragraph (B)5. or (B)6., of this section who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;

5. In the case of an individual described in paragraph (B)7. of this section, 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 (60)-day period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

6. In the case of an individual described in subsection (B) of this section but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment or the effective date of the loss of coverage under the group health plan and ends on the date that is sixty-three (63) days after the effective date.

(D) Extended Medigap Access for Interrupted Trial Periods.

1. In the case of an individual described in paragraph (B)5. of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in subparagraph (B)5.A. of this section is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (10)(B)6.; and

2. In the case of an individual described in paragraph (B)6. of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program

described in paragraph (B)6. of this section is involuntarily terminated within the first twelve (12) 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 (10)(B)6.; and

3. For purposes of paragraphs (B)5. and (B)6. of this section, no enrollment of an individual with an organization or provider described in subparagraph (B)5.A. of this section, or with a plan or in a program described in paragraph (B)6. of this section, may be deemed to be an initial enrollment under this paragraph after the two (2)-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

*[(C)]***(E)** Products to Which Eligible Persons Are Entitled. The Medicare supplement policy to which eligible persons are entitled under—

1. Paragraphs (10)(B)1., 2., 3. and 4. is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F **(including F with a high deductible), K or L** offered by any issuer;

[2. Paragraph (10)(B)5. is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph (C)1. of this section;]

A. Subject to subparagraph B, paragraph (10)(B)5. is the same Medicare supplement policy in which the individual was most recently enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph 1. of this subsection;

B. 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:

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

(II) 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;

*[3.]***2.** Paragraph(10)(B)6. shall include any Medicare supplement policy offered by any issuer; *[and]*

3. Paragraph (10)(B)7. 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; and

4. Paragraph (10)(B)*[7.]***8.** shall include any Medicare supplement policy offered by any issuer but only a policy of the same plan as the coverage in which the individual was most recently enrolled.

*[(D)]***(F)** Notification Provisions.

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

2. At the time of an event described in subsection (B) of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (A) of this section. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

(12) Loss Ratio Standards and Refund or Credit of Premium.

(A) Loss Ratio Standards.

1.

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

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

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

B. The ratios specified in this subsection shall be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. **Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:**

(I) Home office and overhead costs;

(II) Advertising costs;

(III) Commissions and other acquisition costs;

(IV) Taxes;

(V) Capital costs;

(VI) Administrative costs; and

(VII) Claims processing costs.

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

3. For purposes of applying paragraph (A)1. of this section and paragraph *[(C)]***(D)**3. of section (13) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

4. For policies issued prior to July 30, 1992, expected claims in relation to premiums shall meet—

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

B. The appropriate loss ratio requirement from parts (A)1.A.(I) and (II) of this section when combined with actual experience beginning with *[either April 28, 1996, or January 1, 1996]* **January 1, 2006** to date; and

C. The appropriate loss ratio requirement from parts (A)1.A.(I) and (II) of this section over the entire future period for which the rates are computed to provide coverage.

(B) Refund or Credit Calculation.

1. An issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

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

purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

3. For the purposes of this section, policies or certificates issued prior to July 30, 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 *[April 28, 1996]* **January 1, 2006**. The first report shall be due by May 31, *[1998]* **2008**.

4. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a *de minimis* level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen (13)-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(13) Filing and Approval of Policies and Certificates and Premium Rates.

(B) 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 director in the state in which the policy or certificate was issued.

*[(B)]***(C)** 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 director in accordance with the filing requirements and procedures prescribed by the director.

*[(C)]***(D)**

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

2. An issuer may offer, with the approval of the director, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) for each of the following cases:

A. The inclusion of new or innovative benefits;

B. The addition of either direct response or *[agent]* **insurance producer** marketing methods;

C. The addition of either guaranteed issue or underwritten coverage; and

D. The offering of coverage to individuals eligible for Medicare by reason of disability.

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

*[(D)]***(E)**

1. Except as provided in subparagraph 1.A. of this subsection, an issuer shall continue to make available for purchase any policy form or certificate form issued after April 8, 1993, that has been approved by the director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

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

B. An issuer that discontinues the availability of a policy form or certificate form pursuant to subparagraph 1.A. of this subsection shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

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

3. Effect of change in rating structure or methodology.

A. A change in the rating structure or methodology includes, but is not limited to:

(I) A change between community rating, issue-age rating, and attained-age rating;

(II) A change in class structure (e.g., one class v. smoker/non-smoker class, unisex v. male/female classes); and

(III) A change between rating for each age v. age-banded rates.

B. A change in the rating structure or methodology shall be considered a discontinuance under paragraph 1. of this subsection unless the issuer complies with the following requirements:

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

(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. Such actuarially equivalent policies or certificates shall be combined for filing purposes under paragraph (13)*[(G)]***(H)**11. The director may approve a change to the differential which is in the public interest.

C. Notwithstanding subparagraph B. of this paragraph, where an issuer changes a rating structure or methodology and rates calculated under the new methodology are not actuarially equivalent to the old rates, the change in rating structure or methodology will be considered a discontinuance under subparagraph (13)*[(D)]***(E)**1.A. The actuarial equivalency of rates must be determined by a comparison of weighted average premium rate under the old and the new methodology, except in the case of a change between attained-age and issue-age rating where the actuarial equivalency of the rates will be determined from a comparison of actuarial present value of lifetime premiums by age or age-band.

*[(E)]***(F)**

1. Except as provided in paragraph *[(E)]***(F)**2. of this section, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in section (12) of this rule.

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

*[(F)]***(G)**

1. An issuer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after January 1, 2000, based upon attained-age rating as a structure or methodology. Notwithstanding, an issuer may continue in-force policies and certificates issued prior to January 1, 2000.

2. Where an issuer files for approval of a rate structure for policy forms or certificate forms which reflects a change in methodology from attained age to issue age, the issuer must demonstrate the actuarial equivalency of the rates proposed with the previously approved attained-age rates as required by paragraph (13)*[(D)]***(E)**3. If the policy forms or certificate forms were at any time approved by the director under an issue age methodology, the issuer must use the most recently approved issue age rate schedule as its proposed rate schedule for the policy forms or certificate forms and need make no further showing of actuarial equivalency under (13)*[(D)]***(E)**3.

*[(G)]***(H)** Filing requirements and procedures for change of Medicare supplement insurance premium rate and for annual filing of

premium rates.

1. When an issuer files for approval of annual premium rates for a plan under subsection (12)(C) or a change of premium rates for a plan under subsection (13)*[(B)]***(C)**, the following documentation must be provided to the director as part of the rate filing in addition to any other documentation required by law or regulation:

A. A completed Medicare Supplement Rate Filing Document (Missouri Form 375-0065, revised 10/98), which *[is incorporated herein by reference]* **can be accessed at the department's website at www.insurance.mo.gov**;

B. An actuarial memorandum supporting the rating schedule;

C. A report of durational experience (for standardized Medicare supplement plans only);

D. A projection correctly derived from reasonable assumptions;

E. A clear statement of all of the assumptions used to prepare the rate filing, including the source of trend;

F. All formulas used to prepare the projection except for formulas which can be ascertained from a cursory inspection of the projection itself; and

G. The issuer's current rate schedule and the proposed rate schedule for this state, including rates for disabled persons, if any, and all rating factors, including, but not limited to: area; smoker/non-smoker; standard/substandard.

2. The report of durational experience must contain for each calendar year of issue the following data by duration: incurred claims and earned premium; resultant loss ratio; and life-years. The durational split may be either by policy or certificate duration, calendar duration or calendar year of experience within each calendar year of issue.

3. The projection must—

A. State the incurred claims and earned premium, resultant loss ratio and corresponding life-years for each of the preceding calendar years beginning with the year in which the policy or certificate was first issued and must include the total for each category (incurred claims and earned premium, resultant loss ratio, and corresponding life-years) for all preceding calendar years;

B. State the projected incurred claims and projected earned premium, resultant loss ratios and corresponding life-years for at least each of the ten (10) calendar years subsequent to the rate filing and must include the total for each category (projected incurred claims and projected earned premium, resultant loss ratio, and corresponding life-years) for all projected calendar years;

C. Include a calculation of the sums of the combined total figures reported under subparagraph A. of this paragraph and those reported under subparagraph B. of this paragraph; and

D. Include, for pre-standardized Medicare supplement plans, the respective totals of the incurred claims and earned premium, resultant loss ratio, and corresponding life-years for the period beginning April 28, 1996, or alternatively, January 1, 1996, through the end of the projection period described in subparagraph B. of this paragraph.

4. Where assumptions include interest, the totals for incurred claims accumulated/discounted with interest, earned premium accumulated/discounted with interest, and the resultant loss ratio must also be shown in all parts of the projection described in paragraph *[(G)]***(H)**3. of this section.

5. Both the report of durational experience and the projection must report Missouri and national data with respect to incurred claims, earned premium, loss ratio, and life-years. The projection must also report this information both with and without the rate change requested.

6. The issuer must specify whether the figures reported as incurred claims were determined by adding claims paid to unpaid claims reserves or by the actual runoff of claims. The method of determining the incurred claims must be consistent throughout the filing and supporting documentation.

7. Changes in active life reserves or claims expenses may not be included in incurred claims in the rate filing or any supplemental documentation.

8. For purposes of this section, "incurred claims" means the dollar amount of incurred claims.

9. Earned premium reported in the rate filing or any supporting documentation must include modal loadings and policy fees. An adjustment for premium refunds, if any, must also be made to earned premium and the details of the adjustment must be provided to the director with the filing. Changes in active life reserves may not be included in earned premium.

10. Life-years reported in a rate filing or supplemental documentation must be calculated in the same manner as for refund calculations.

11. Rate filings for each plan, type, and form level permitted under subsection (13)*[(C)]***(D)** for standardized Medicare supplement plans marketed after June 30, 1998, must demonstrate compliance with the requirements of subsection (9)(E). The "weighted average aged premium," must be recalculated for each filing using current data, unless the issuer demonstrates compliance under subparagraph (9)(E)1.A. The figure used in the calculation for the total number of insureds in-force for all age bands, age sixty-five (65) and over, must be the same as the figure reported on Missouri Form 375-0065 for the "Number of Missouri Aged Insureds."

12. For standardized Medicare supplement plans, the Medicare Supplement Rate Filing Document, the report of durational experience, and the projection must be provided separately for each plan, type, and form level permitted under subsection (13)*[(C)]***(D)**.

13. For pre-standardized Medicare supplement rate plans, the information contained in the Medicare Supplement Rate Filing Document and projection may be pooled within a type.

14. The rates, rating schedule and supporting documentation required to be filed under subsection *[(G)]***(H)** of this section as part of a rate filing and all supplementary documentation in connection with the rate filing must be accompanied by the certification of a qualified actuary that to the best of the actuary's knowledge and judgment, the following items are true with respect to the documentation submitted:

A. The assumptions present the actuary's best judgment as to the expected value for each assumption and are consistent with the issuer's business plan at the time of the filing;

B. The anticipated lifetime, future, and third-year loss ratios for the policy form or certificate form for which the rates are filed comply with the loss ratio requirements of subsection (12)(A) for policy forms or certificate forms of its type delivered or issued for delivery in this state;

C. With respect to rate filings concerning pre-standardized plans, the loss ratio for year 1996 (from April 28 or from January 1) through the end of the projection period complies with the loss ratio requirements of subsection (12)(A) for policies or certificates issued prior to July 30, 1992, and delivered or issued for delivery in this state;

D. Where the rate filing concerns a policy or certificate as to which rating methodologies have changed or are presented for approval based on a change in methodology, the percentage differential between the discontinued and subsequent (or new) rates has not changed;

E. All components of the filing, including rates, rating schedules, and supporting documentation, were prepared based on the current standards of practice promulgated by the Actuarial Standards Board;

F. The rate filing, including rates, rating schedule, and supporting documentation, is in compliance with the applicable laws and regulations of this state; and

G. The rates requested are reasonable in relationship to the benefits provided by the policy or certificate.

(14) Permitted Compensation Arrangements.

(A) An issuer or other entity may provide commission or other compensation to an *[agent]* **insurance producer** 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 percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(C) No issuer or other entity shall provide compensation to its *[agents or other producers]* **insurance 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.

(15) Required Disclosure Provisions.

(A) General Rules.

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

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

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

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

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

6.

A. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the *[Health Care Financing Administration]* **Centers for Medicare and Medicaid Services (CMS)** and in a type size no smaller than twelve (12)-point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this 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.

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

(C) MMA Notice Requirements. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

*[(C)]***(D)** Outline of Coverage Requirements for Medicare Supplement Policies.

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

2. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve (12)-point type, immediately above the company name: **"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."**

3. The outline of coverage provided to applicants pursuant to this section consists of four (4) parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12)-point type. All plans A–*[J]***L** shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

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

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page: ***1 of 2***

Benefit Plans ______ [insert letters of plans being offered

[Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans.] [These] ***This*** chart*[s]* show*[s]* the benefits included in each ***of the standard Medicare supplement*** plans. Every company must make available Plan "A." Some plans may not be available in your state.

See Outlines of Coverage sections for details about ALL plans

Basic Benefits *[Included in All Plans]* ***for Plans A - J:***
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or*[, in the case of hospital outpatient department services under a prospective payment system, applicable]* copayments ***for hospital outpatient services.***
Blood: First three pints of blood each year.

A	B	C	D	E	F F*	G	H	I	J J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing ***Facility*** Co*[-I]* insurance	Skilled Nursing ***Facility*** Co*[-I]* insurance	Skilled Nursing ***Facility*** Co*[-I]* insurance	Skilled Nursing ***Facility*** Co*[-I]* insurance	Skilled Nursing ***Facility*** Co*[-I]* insurance	Skilled Nursing ***Facility*** Co*[-I]* insurance	Skilled Nursing ***Facility*** Co*[-I]* insurance	Skilled Nursing ***Facility*** Co*[-I]* insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							[Basic Drugs ($1250 Limit)]	*[Basic Drugs ($1250 Limit)]*	*[Extended Drugs ($3000 Limit)]*
				Preventive Care ***NOT covered by Medicare***					Preventive Care ***NOT covered by Medicare***

*** Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same** *[or offer the same]* **benefits as Plans F and J after one has paid a calendar year [$1690] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do***[es]* **not include*****[, in plan J]*** **the plan's separate** *[prescription drug deductible or, in plans F and J, the plan's]* **foreign travel emergency deductible.**

[COMPANY NAME]
Outline of Medicare Supplement Coverage-Cover Page 2
Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	*K***	*L***
Basic Benefits	*100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End* *50% Hospice cost-sharing* *50% of Medicare-eligible expenses for the first three pints of blood* *50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services*	*100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End* *75% Hospice cost-sharing* *75% of Medicare-eligible expenses for the first three pints of blood* *75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services*
Skilled Nursing Coinsurance	*50% Skilled Nursing Facility Coinsurance*	*75% Skilled Nursing Facility Coinsurance*
Part A Deductible	*50% Part A Deductible*	*75% Part A Deductible*
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	*$[4000] Out of Pocket Annual Limit****	*$[2000] Out of Pocket Annual Limit****

*** Plans K and L provide for different cost-sharing for items and services than Plans A – J.*
Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.
****The out-of-pocket annual limit will increase each year for inflation.*

See Outlines of Coverage for details and exceptions.

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

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

RIGHT TO RETURN POLICY [Boldface Type]

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

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for ***insurance producers***:]
Neither [insert company's name] nor its ***insurance producers*** are connected with Medicare.

[for direct response:]
[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

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

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

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this rule. An issuer may use additional benefit plan designations on these charts pursuant to Section (7)(D) of this rule.]

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but $*[[764]]* ***[876]*** All but $*[[191]]* ***[219]*** a day All but $*[[382]]* ***[438]*** a day $0 $0	$0 $*[[191]]* ***[219]*** a day $*[[382]]* ***[438]*** a day 100% of Medicare eligible expenses $0	$*[[764]]* ***[876]***(Part A deductible) $0 $0 $0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but $*[[95.50]]* ***[109.50]*** a day $0	$0 $0 $0	$0 Up to $*[[95.50]]* ***[109.50]*** a day All costs
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

***** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare Approved Amounts*	$0	$0	$ [100] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
[Part B Excess Charges (Above Medicare Approved Amounts)]	*[$0]*	*[$0]*	*[All costs]*
Part B Excess Charges (Above Medicare Approved Amounts)	***$0***	***$0***	***All costs***
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare Approved Amounts*	$0	$0	$ [100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—*[BLOOD]*TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $*[[764]]* ***[876]***	$*[[764]]* ***[876]***(Part A deductible)	$0
61st thru 90th day	All but $*[[191]]* ***[219]*** a day	$*[[191]]* ***[219]*** a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $*[[382]]* ***[438]*** a day	$*[[382]]* ***[438]*** a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $*[[95.50]]* ***[109.50]*** a day	$0	Up to $*[[95.50]]* ***[109.50]*** a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

***** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $*[*100*]* of Medicare Approved Amounts*	$0	$0	$*[*100*]* (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
[Part B Excess Charges (Above Medicare Approved Amounts)]	*[$0]*	*[$0]*	*[All costs]*
Part B Excess Charges (Above Medicare Approved Amounts)	***$0***	***$0***	***All costs***
BLOOD			
First 3 pints	$0	All costs	$0
Next $*[*100*]* of Medicare Approved Amounts*	$0	$0	$*[*100*]* (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—*[BLOOD]* TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $*[[764]]* ***[876]***	$*[[764]]* ***[876]***(Part A deductible)	$0
61st thru 90th day	All but $*[[191]]* ***[219]*** a day	$*[[191]]* ***[219]*** a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $*[[382]]* ***[438]*** a day	$*[[382]]* ***[438]*** a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $*[[95.50]]* ***[109.50]*** a day	Up to $*[[95.50]]* ***[109.50]*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

***** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare Approved Amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
[Part B Excess Charges (Above Medicare Approved Amounts)]	*[$0]*	*[$0]*	*[All costs]*
Part B Excess Charges (Above Medicare Approved Amounts)	***$0***	***$0***	***All costs***
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare Approved Amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—*[BLOOD]* TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $*[[764]]* ***[876]***	$*[[764]]* ***[876]*** (Part A deductible)	$0
61st thru 90th day	All but $*[[191]]* ***[219]*** a day	$*[[191]]* ***[219]*** a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $*[[382]]* ***[438]*** a day	$*[[382]]* ***[438]*** a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $*[[95.50]]* ***[109.50]*** a day	Up to $*[[95.50]]* ***[109.50]*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

***** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
[Part B Excess Charges (Above Medicare Approved Amounts)]	*[$0]*	*[$0]*	*[All costs]*
Part B Excess Charges (Above Medicare Approved Amounts)	***$0***	***$0***	***All costs***
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—*[BLOOD]* TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $*[100]* of Medicare Approved Amounts*	$0	$0	$*[100]* (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan —Benefit for each visit	$0	Actual charges to $40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $*[[764]]* ***[876]***	$*[[764]]* ***[876]*** (Part A deductible)	$0
61st thru 90th day	All but $*[[191]]* ***[219]*** a day	$*[[191]]* ***[219]*** a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $*[[382]]* ***[438]*** a day	$*[[382]]* ***[438]*** a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $*[[95.50]]* ***[109.50]*** a day	Up to $*[[95.50]]* ***[109.50]*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

***** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
[Part B Excess Charges (Above Medicare Approved Amounts)]	*[$0]*	*[$0]*	*[All costs]*
Part B Excess Charges (Above Medicare Approved Amounts)	***$0***	***$0***	***All costs***
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare Approved Amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—*[BLOOD]* TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

(continued)

PLAN E

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
*****PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services *[such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education,]* administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

[This high deductible plan pays the same** *[or offers the same]* **benefits as Plan F after one has paid a calendar year** *[[$1500]]* ***[$1690]*** **deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are** *[[$1500]]* ***[$1690]*. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[[1500]] [1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[[1500]] [1690] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $*[[764]]* ***[876]***	$*[[764]]* ***[876]*** (Part A deductible)	$0
61st thru 90th day	All but $*[[191]]* ***[219]*** a day	$*[[191]]* ***[219]*** a day	$0
91st day and after:			
While using 60 Lifetime reserve days	All but $*[[382]]* ***[438]*** a day	$*[[382]]* ***[438]*** a day	$0
Once lifetime reserve days Are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $*[[95.50]]* ***[109.50]*** a day	Up to $*[[95.50]]* ***[109.50]*** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

(continued)

****** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.***

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

[This high deductible plan pays the same** *[or offers the same]* **benefits as Plan F after one has paid a calendar year** *[[$1500]]* ***[$1690]*** **deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are** *[[$1500]]* ***[$1690]*****. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[[1500]] [1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[[1500]] [1690] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician's Services, inpatient and Outpatient medical and Surgical services and Supplies, physical and Speech therapy, Diagnostic tests, Durable medical Equipment,			
First $[100] of Medicare Approved amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare Approved amounts	Generally 80%	Generally 20%	$0
[Part B excess charges (Above Medicare approved amounts)]	*[$0]*	*[100%]*	*[$0]*
Part B excess charges (Above Medicare Approved Amounts)	***$0***	***100%***	***$0***
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare Approved amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—*[BLOOD]* TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	*MEDICARE PAYS*	*[AFTER YOU PAY $[1690] DEDUCTIBLE,** PLAN PAYS]*	*[IN ADDITION TO $[1690] DEDUCTIBLE,** YOU PAY]*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $*[*100*]* of Medicare approved Amounts*	$0	$*[*100*]* (Part B deductible)	$0
Remainder of Medicare approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	**MEDICARE PAYS**	***[*AFTER YOU PAY $*[[1500]] [1690]* DEDUCTIBLE,*****]* PLAN PAYS**	***[*IN ADDITION TO $*[[1500]] [1690]* DEDUCTIBLE,*****]* YOU PAY**
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum