



Rules of Department of Commerce and Insurance

Division 400—Life, Annuities and Health Chapter 3—Medicare Supplement Insurance

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

**20 CSR 400-3.100 Rule to Implement
Transitional Requirements for the Conver-
sion of Medicare Supplement Insurance
Benefits and Premiums to Conform to
Medicare Program Revisions**

PURPOSE: This rule attempts to assure the orderly implementation and conversion of Medicare supplement insurance benefits and premiums due to changes in the federal Medicare program; provides for the reasonable standardization of the coverage, terms and benefits of Medicare supplement policies or contracts; facilitates public understanding of these policies or contracts; eliminates provisions contained in these policies or contracts which may be misleading or confusing in connection with the purchase of these policies or contracts to eliminate policy or contract provisions which may duplicate Medicare benefits; provides full disclosure of policy or contract benefits and benefit changes; and provides for refunds of premiums associated with benefits duplicating Medicare program benefits. This rule is promulgated pursuant to sections 376.850—376.890, RSMo.

(1) Applicability and Scope. This regulation shall take precedence over other rules and requirements relating to Medicare supplement policies or contracts only to the extent necessary to assure that benefits are not duplicated, that applicants receive adequate notice and disclosure of changes in Medicare supplement policies and contracts, that appropriate premium adjustments are made in a timely manner and that premiums are reasonable in relation to benefits. Except as otherwise provided, this rule shall apply to—

(A) All Medicare supplement policies and contracts delivered, or issued for delivery, or which are otherwise subject to the jurisdiction of this state on or after October 27, 1988; and

(B) All certificates issued under group Medicare supplement policies as provided in subsection (1)(A).

(2) Definitions. For purposes of this rule—

(A) Applicant means—

1. In the case of an individual Medicare supplement policy or contract, the person who seeks to contract for insurance benefits; and

2. In the case of a group Medicare policy or contract, the proposed certificate holder;

(B) Certificate means any certificate issued under a group Medicare supplement policy, which policy has been delivered, or issued for delivery, in this state; and

(C) Medicare supplement policy means a group or individual policy of accident and health insurance, or a subscriber contract of health service corporations, which is advertised, marketed or designed primarily to supplement coverage for hospital, medical or surgical expenses incurred by an insured person which are not covered by Medicare. This term does not include:

1. A policy or contract of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) or more employers or labor organizations, or combination of them, for employees or former employees, or combination of them, or for members or former members, or combination of them, of the labor organizations;

2. A policy or contract of any professional, trade or occupational association for its members or former or retired members, or combination of them, if the association—

A. Is composed of individuals all of whom are actively engaged in the same profession, trade or occupation;

B. Has been maintained in good faith for purposes other than obtaining insurance; and

C. Has been in existence for at least two (2) years prior to the date of its initial offering of the policy or plan to its members; or

3. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions which are inconsistent with the requirements of sections 376.850—376.885, RSMo nor to Medicare supplement policies being issued to employees or members as additions to franchise plans in existence on July 1, 1982.

(3) Benefit Conversion Requirements.

(A) Effective January 1, 1989, no Medicare supplement insurance policy, contract or certificate in force in this state shall contain benefits which duplicate benefits provided by Medicare.

(B) General Requirements.

1. No later than thirty (30) days prior to the annual effective date of Medicare benefit changes mandated by the Medicare Catastrophic Coverage Act of 1988, every insurer, health care service plan or other entity providing Medicare supplement insurance or

benefits to a resident of this state shall notify its policyholders, contract holders and certificate holders of modifications it has made to Medicare supplement insurance policies or contracts. This notice shall be in a format prescribed by the director or in a format adopted by the National Association of Insurance Commissioners (NAIC) in June of 1988 if no other format is prescribed by the director.

2. No modifications to any existing Medicare supplement contract or policy shall be made at the time of or in connection with the notice requirements of this regulation, except to the extent necessary to eliminate duplication of Medicare benefits and any modifications necessary under the policy or contract to provide indexed benefit adjustment.

3. As soon as practicable, but no longer than forty-five (45) days after the effective date of the Medicare benefit changes, every insurer, health care service plan or other entity providing Medicare supplement insurance or contracts in this state shall file with the division, in accordance with the applicable filing procedures of this state—

A. Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts. Supporting documents as necessary to justify the adjustment shall accompany the filing; and

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

4. Upon satisfying the filing and approval requirements of this state, every insurer, health care service plan or other entity providing Medicare supplement insurance in this state shall provide each covered person with any rider, endorsement or policy form necessary to eliminate any benefit duplications under the policy or contract with benefits provided by Medicare. In the event a covered person must be issued a new policy, contract or certificate to eliminate benefit duplications, the insurer shall credit the covered person with all deductible amounts which have been incurred under the prior policy, contract or certificate and with all time periods for pre-existing condition satisfied under the prior coverage.

5. No insurer, health care service plan or other entity shall require any person covered under a Medicare supplement policy or contract which was in force prior to January



1, 1989 to purchase additional coverage under the policy or contract unless additional coverage was provided for in the policy or contract.

6. Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this state shall make the premium adjustments that are necessary to produce an expected loss ratio under the policy or contract as will conform with minimum loss ratio standards for Medicare supplement policies and which is expected to result in a loss ratio at least as great as that originally anticipated by the insurer, health care service plan or other entity for Medicare supplement insurance policies or contracts. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described in this rule should be made with respect to a policy at any time other than upon its renewal date. Premium adjustments shall be in the form of refunds or premium credits and shall be made no later than upon renewal if a credit is given, or within sixty (60) days of the renewal date if a refund is provided to the premium payer.

(4) Requirements for New Policies and Certificates.

(A) Effective January 1, 1989 no Medicare supplement insurance policy, contract or certificate shall be issued or issued for delivery in this state which provides benefits which duplicate benefits provided by Medicare. No Medicare supplement insurance policy, contract or certificate shall provide fewer benefits than those required under existing Medicare Supplement Minimum Standards Act or regulations except where duplication of Medicare benefits would result.

(B) General Requirements.

1. Within ninety (90) days (January 25, 1989) of the effective date of this rule (October 27, 1988), every insurer, health care service plan or other entity required to file its policies or contracts with this state shall file new Medicare supplement insurance policies or contracts which eliminate any duplication of Medicare supplement benefits with benefits provided by Medicare and which provide a clear description of the policy or contract benefit.

2. The filing required under paragraph (4)(B)1. shall provide for loss ratios which are in compliance with all minimum standards.

3. Every applicant for a Medicare supplement insurance policy, contract or certificate shall be provided with an outline of coverage which simplifies and accurately describes benefits provided by Medicare and

policy or contract benefits along with benefit limitations.

(5) Filing Requirements for Advertising. Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits in this state shall provide a copy of any advertisement intended for use in this state whether through written, radio or television medium to the director of insurance of this state for review by the director. This advertisement shall be submitted to the director no later than the first day on which the advertisement is used. The department shall stamp each advertisement in a manner which indicates that it has been reviewed but that the review does not constitute approval by the department. All Medicare supplement advertisements will be retained for thirty (30) days before being returned to the company. The advertisement shall comply with all applicable laws and rules of this state.

(6) Buyer's Guide. No insurer, health care service plan or other entity shall make use of or otherwise disseminate any buyer's guide or informational brochure which does not accurately outline current Medicare benefits and which has not been adopted by the director.

(7) Separability. If any provision of this regulation or the application of it to any persons or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of that provision to other persons or circumstances shall not be affected by it.

*AUTHORITY: section 374.045, RSMo (1986). * This rule was previously filed as 4 CSR 190-14.112. Original rule filed July 5, 1988, effective Oct. 27, 1988.*

**Original authority 1967.*

20 CSR 400-3.200 Medicare Supplement Insurance Minimum Standards

PURPOSE: This rule provides for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; facilitates public understanding and comparison of these policies; eliminates provisions contained in the policies which may be misleading or confusing in connection with the purchase of the policies or with the settlement of claims; and provides for full disclosure in the sale of accident and sickness insurance coverages to persons eligible for Medicare by reason of age.

(1) Applicability and Scope. Except as otherwise specifically provided, this rule shall—

(A) Apply to all Medicare supplement policies and subscriber contracts delivered or issued for delivery in this state on or after November 1, 1989;

(B) Apply to all certificates issued under group Medicare supplement policies or subscriber contracts, which certificates have been delivered or issued for delivery in this state; and

(C) Not apply to a policy or contract of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) or more employers or labor organizations or combination of them, for employees or former employees or a combination of them, or for members or former members or combination of them of the labor organizations.

(2) Definitions. For the purposes of this rule—

(A) Applicant means—

1. In the case of an individual Medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits; and

2. In the case of a group Medicare supplement policy or subscriber contract, the proposed certificate holder;

(B) Certificate means any certificate issued under a group Medicare supplement policy, which certificate had been delivered or issued for delivery in this state; and

(C) Medicare supplement policy means a group or individual policy of accident and sickness insurance or a subscriber contract of a health services corporation or health maintenance organization (HMO) which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age.

(3) Policy Definitions and Terms. No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy unless that policy or subscriber contract contains definitions or terms which substantially conform to the requirements of this section.

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

1. The definition shall not be more restrictive than the following: Injury(ies) for which benefits are provided means accidental



bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force.

2. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any Workers' Compensation, employer's liability or similar law or motor vehicle no-fault plan, unless prohibited by law.

(B) Benefit period or Medicare benefit period shall not be defined as more restrictive than that defined in the Medicare program.

(C) Convalescent nursing home, extended care facility or skilled nursing facility shall be defined in relation to its status, facilities and available services.

1. A definition of such home or facility shall not be more restrictive than one requiring that it—

A. Be operated pursuant to law;

B. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

C. Provide continuous twenty-four (24) hour-a-day nursing service by care under the supervision of a registered graduate professional nurse (RN); and

D. Maintain a daily medical record of each patient.

2. The definition of such home or facility may provide that the term not be inclusive of—

A. Any home, facility or part of it used primarily for rest;

B. A home or facility used for the aged or for the care of drug addicts or alcoholics; or

C. A home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

(D) Health care expenses means expenses of HMOs associated with the delivery of health care services which are analogous to incurred losses of insurers. These expenses shall not include:

1. Home office or overhead costs;
2. Advertising costs;
3. Commissions and other acquisition costs;
4. Taxes;
5. Capital costs;
6. Administrative costs; or
7. Claims processing costs.

(E) Hospital may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

1. The definition of the term hospital shall not be more restrictive than one requiring that the hospital—

A. Be an institution operated pursuant to law;

B. Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which charge is made; and

C. Provide twenty-four (24) hour nursing service by or under the supervision of RNs.

2. The definition of the term hospital may state that the term shall not be inclusive of—

A. Convalescent homes or convalescent, rest or nursing facilities;

B. Facilities primarily affording custodial, educational or rehabilitative care;

C. Facilities for the aged, drug addicts or alcoholics; or

D. Any military or veterans' hospital or soldiers' home or any hospital contracted for or operated by any national government or agency of it for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for those services.

(F) Medicare shall be defined in the policy. Medicare may be substantially defined as The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 or Title I, Part I of P.L. 89-97, as enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, or words of similar import.

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

(H) Mental or nervous disorders shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

(I) Nurses may be defined so that the description of nurse is restricted to a type of nurse, such as an RN, a licensed practical nurse (LPN) or a licensed vocational nurse (LVN). If the words nurse, trained nurse or

registered nurse are used without specific instruction, then the use of the terms requires the insurer to recognize the services of any individual who qualifies under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(J) Physician may be defined by including words such as duly qualified physician or duly licensed physician. The use of these terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when these services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(K) Sickness shall not be defined to be more restrictive than the following: sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. The definition may be further modified to exclude sickness or diseases for which benefits are provided under any Workers' Compensation, occupational disease, employer's liability or similar law.

(4) Prohibited Policy Provisions.

(A) No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or subscriber contract limits or excludes coverage by type of illness, accident, treatment or medical condition, except as follows:

1. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;

2. Mental or emotional disorders, alcoholism and drug addiction;

3. Illness, treatment or medical condition arising out of—

A. War or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; or service in the armed forces or auxiliary units of it;

B. Suicide or attempted suicide (while sane) or intentionally self-inflicted injury; and

C. Aviation;

4. Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when that service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;

5. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effect of it, where that interference is the result of



or related to distortion, misalignment or subluxation of or in the vertebral column;

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

7. Dental care or treatment;

8. Eyeglasses, hearing aids and examination for the prescription or fitting of these;

9. Rest cures, custodial care, transportation and routine physical examinations; and

10. Territorial limitations outside the United States. Provided, however, supplemental policies may not contain, when issued, limitations or exclusions of the type enumerated in paragraph (4)(A)1., 2., 5., 9. or 10. that are more restrictive than those of Medicare. Medicare supplement policies may exclude coverage for any expense to the extent of any benefit available to the insured under Medicare.

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

(C) The terms Medicare supplement, Medigap and words of similar import shall not be used unless the policy is issued in compliance with this rule.

(D) No Medicare supplement insurance policy, contract or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare.

(5) Minimum Benefit Standards. No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy which does not meet the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards:

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

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

medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage;

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

3. A Medicare supplement policy shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with these 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 insurer solely on the grounds of deterioration of health; and

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

(B) Minimum Benefit Standards.

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

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

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

4. Until January 1, 1990, coverage for twenty percent (20%) of the amount of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of two hundred dollars (\$200) of expenses and to a maximum benefit of at least five thousand dollars (\$5000) per calendar year. Effective January 1, 1990 coverage for the copayment amount of Medicare-eligible expenses excluding outpatient prescription

drugs under Medicare Part B regardless of hospital confinement up to the maximum out-of-pocket amount for Medicare Part B after the Medicare deductible amount.

5. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells as defined under federal regulations) unless replaced in accordance with federal regulations.

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

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

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

(6) Standards for Claims Payment.

(A) Every entity providing Medicare supplement policies or contracts shall comply with all provisions of Section 4081 of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203).

(B) Compliance with the requirements set forth in subsection (6)(A) must be certified on the Medicare Supplement Insurance Experience exhibit attached to the annual statement.

(C) No policy or certificate may contain a provision reducing benefit payments due to the existence of other Medicare supplement coverage. Coverage must provide that insureds are entitled to a return of all premiums paid for duplicate coverage with the same insurer.

(7) Loss Ratio Standards.

(A) Medicare supplement policies shall return to policyholders in the form of aggregate benefits under the policy, for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience or incurred health care expenses where coverage is provided by an HMO on a



service rather than reimbursement basis and earned premiums for that period and in accordance with accepted actuarial principles and practices—

1. At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies, or direct response policies issued on or after January 1, 1990; and

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

(B) All filings of rates and rating schedules shall demonstrate that actual and expected losses in relation to premiums comply with the requirements of this section.

(C) Every entity providing Medicare supplement policies in this state annually shall file its rates, rating schedule and any supporting documentation requested by the director, including ratios of incurred losses to earned premiums by number of years of policy duration, demonstrating that it is in compliance with the previously mentioned applicable loss ratio standards and that the period for which the policy is rated is reasonable in accordance with accepted actuarial principles and experience. For the purposes of this section, policy forms shall be deemed to comply with the loss ratio standards if—i) for the most recent year, the ratio of the incurred losses to earned premiums for policies or certificates which have been in force for three (3) years or more is greater than or equal to the applicable percentages contained in this section and ii) the expected losses in relation to premiums over the entire period for which the policy is rated comply with the requirements of this section. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

(D) In determining compliance with the loss ratio standards in subsections (7)(A)—(C) actual and expected incurred losses shall not include:

1. Loss adjustment expense incurred in settling claims; or

2. Claim reserves that would be found unreasonably excessive or unacceptable by actuarial standards, procedures and practices.

(E) As soon as practicable, but no later than sixty (60) days prior to the effective date of Medicare benefit changes required by the Medicare Catastrophic Coverage Act of 1988, every insurer, health care service plan or other entity providing Medicare supplement insurance or contracts in this state (except employers subject to the requirements of Section 421 of the Medicare Catastrophic Coverage Act of 1988) shall file with the director in accordance with the applicable filing procedures of this state—

1. Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts. These supporting documents, as necessary to justify the adjustment, shall accompany the filing. Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this state pursuant to Section 2 of the Medicare Supplement Insurance Minimum Standards Model Act shall make whatever premium adjustments are necessary to produce an expected loss ratio under the policy or contract that will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the insurer, health care service plan or other entity for those Medicare supplement insurance policies or contracts. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described in this rule should be made with respect to a policy at any time other than upon its renewal date or anniversary date. Premium adjustments shall be in the form of refunds or premium credits and shall be made no later than upon renewal if a credit is given, or within sixty (60) days of the renewal date or anniversary date if a refund is provided to the premium payer. Premium adjustments shall be calculated for the period commencing with Medicare benefit changes; and

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

(8) Filing Requirements for Out-of-State Group Policies. Every insurer providing group Medicare supplement insurance benefits to a resident of this state pursuant to Section 2 of the Medicare Supplement Insurance Minimum Standards Model Act shall file a copy of the master policy and any certificate used in this state in accordance with the filing requirements and procedures applicable to group Medicare supplement policies issued in this state; provided, however, that no insurer shall be required to make a filing earlier than thirty (30) days after insurance was provided to a resident of this state under a master policy issued for delivery outside this state.

(9) Prohibited Compensation for Replacement with the Same Company. No entity shall provide compensation to its agents or

other producers which is greater than the renewal compensation which would have been paid on an existing policy if the existing policy is replaced by another policy with the same company where the new policy benefits are substantially similar to the benefits under the old policy and the old policy was issued by the same insurer or insurer group.

(10) Required Disclosure Provisions.

(A) General Rules.

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

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

3. A Medicare supplement policy which provides for the payment of benefits based on standards described as usual and customary, reasonable and customary or words of similar import shall include definitions and explanations of the terms in its accompanying outline of coverage.

4. If a Medicare supplement policy contains any limitations with respect to pre-existing conditions, the limitations must appear as a separate paragraph of the policy and be labeled as preexisting condition limitations.

5. Medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or certificate, or attached to it 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. Insurers issuing accident and sickness policies, certificates or subscriber contracts which provide hospital or medical expense coverage on an expense-incurred or indemnity basis, other than incidentally, to a person(s) eligible for Medicare by reason of age shall provide to all applicants a Medicare supplement Buyer's Guide in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration. Delivery of the Buyer's Guide shall be made whether or not the policies, certificates or subscriber contracts are advertised, solicited or issued as Medicare supplement policies as defined in this regulation. Except in the case of direct response insurers, delivery of the Buyer's Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Buyer's Guide shall be obtained by the insurer. Direct response insurers shall deliver the Buyer's Guide to the applicant upon request but not later than at the time the policy is delivered.

(B) Notice Requirements.

1. As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this state shall notify its policyholders, contract holders and certificate holders of modifications it has made to Medicare supplement insurance policies or contracts in a format acceptable to the director. For the years 1989 and 1990, and if prescription drugs are covered in 1991, the notice shall be in a format prescribed by the director or in the format prescribed in Appendices A, B and C if no other format is prescribed by the director. In addition, the notice shall—

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

B. Inform each covered person as to when any premium adjustment is to be made due to changes in Medicare.

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

3. The notices shall not contain or be accompanied by any solicitation.

(C) Outline of Coverage Requirements for Medicare Supplement Policies.

1. Insurers issuing Medicare supplement policies or certificates for delivery in this

state shall provide an outline of coverage to all applicants at the time application is made and, except for direct response policies, shall obtain an acknowledgment of receipt of 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 must 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.

(D) Notice Regarding Policies or Subscriber Contracts Which Are Not Medicare Supplement Policies. Any accident and sickness insurance policy or subscriber contract other than a Medicare supplement policy, disability income policy, basic, catastrophic or major medical expense policy, single premium nonrenewable policy or other policy identified in subsection (1)(B) of this rule, issued for delivery in this state to persons eligible for Medicare by reason of age shall notify insureds under the policy or subscriber contract that the policy or subscriber contract is not a Medicare supplement policy. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy or subscriber contract or, if no outline of coverage is delivered, to the first page of the policy, certificate or subscriber contract delivered to insureds. The notice shall be in no less than twelve (12)-point type and shall contain the following language: "THIS (POLICY, CERTIFICATE OR SUBSCRIBER CONTRACT) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CONTRACT). If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company."

(11) Requirements for Replacement.

(A) Application forms shall include a question designed to elicit information as to whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

(B) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of

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

(C) The notice required by subsection (11)(B) for an insurer, other than a direct response insurer, shall be provided in substantially the form as indicated in Appendix B.

(D) The notice required by subsection (11)(B) for a direct response shall be as indicated in Appendix C.

(12) Filing Requirements for Advertising. Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits in this state shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the (director) of insurance of this state for review or approval by the (director) to the extent it may be required under state law.

(13) Separability. If any provision of this rule or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of that provision to other persons or circumstances shall not be affected by it.

(14) Effective Date. This rule shall be effective on November 1, 1989.

AUTHORITY: sections 376.864, 376.869, 376.874 and 376.879, RSMo (Cum. Supp. 1989). This rule was previously filed as 4 CSR 190-14.113. Emergency rule filed July 18, 1989, effective Sept. 1, 1989, expired Oct. 31, 1989. Original rule filed July 18, 1989, effective Nov. 1, 1989.

**Original authority: 376.864, RSMo (1989), amended 1992; 376.869 and 376.874, RSMo (1989); and 376.879, RSMo (1989), amended 1992.*



APPENDIX A

(COMPANY NAME)
**OUTLINE OF MEDICARE
 SUPPLEMENT COVERAGE**

- i. Read your policy carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
2. Medicare Supplement Coverage—Policies of this category are designed to supplement Medicare by covering some hospital, medical and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient charges and some physician charges, subject to any deductibles and copayment provisions which may be in addition to those provided by Medicare and subject to other limitations which may be set forth in the policy. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine (delete if such coverage is provided).
3. A. (for agents): Neither (*insert company's name*) nor its agents are connected with Medicare.
 B. (for direct responses): (*insert company's name*) is not connected with Medicare.
4. (A brief summary of the major medical benefit gaps in Medicare Parts A & B with a parallel description of supplemental benefits, including dollar amounts (and indexed copayments or deductibles, as appropriate) provided by the Medicare supplement coverage in the following order:)

DESCRIPTION	THIS POLICY PAYS	YOU PAY
SERVICE		
PART A		
INPATIENT HOSPITAL SERVICES:		
Semiprivate Room & Board		
Miscellaneous Hospital Services & Supplies, such as Drugs, X rays, Lab Tests & Operating Room		
SKILLED NURSING FACILITY CARE		
BLOOD		
PARTS A & B		
Home Health Services		
PART B		
MEDICAL EXPENSE:		
Services of a Physician/ Outpatient Services		
Medical Supplies Other Than Prescribed Drugs		
BLOOD		



DESCRIPTION	THIS POLICY PAYS	YOU PAY
SERVICE		
MAMMOGRAPHY SCREENING		
OUT OF POCKET MAXIMUM		
PRESCRIPTION DRUGS		
MISCELLANEOUS		
Home I.V.-Drug Therapy		
Immunosuppressive Drugs		
Respite Care Benefits		

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

5. *(The following charts shall accompany the outline of coverage.)*



APPENDIX A
Part A
MEDICARE BENEFITS IN

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

Skilled Nursing Facility Care	100% of costs for 1st 20 days (after a 3 day prior hospital confinement) All but \$67.50 a day for 1st—100th days Nothing beyond 100 days	80% of Medicare reasonable costs for first 8 days per calendar year w/out prior hospitalization requirement 100% of costs thereafter up to 150 days/calendar year	80% for 1st 8 days/calendar year 100% for 9th—150th day/calendar year	80% for 1st 8 days/calendar year 100% for 9th—150th day/calendar year

Blood	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in <u>each benefit period</u>	Pays all costs except payment of deductible (equal to costs for first 3 pints) <u>each calendar year</u> . Part A blood deductible reduced to the extent paid under Part B	All but blood deductible (equal to costs for first 3 pints)	All but blood deductible (equal to costs for first 3 pints)



APPENDIX A

Part B
MEDICARE BENEFITS IN

Service	1988	1989	1990	1991
PARTS A & B				
Home Health Services	Intermittent skilled nursing care and other services in the home (daily skilled nursing care for up to 21 days or longer in some cases)—100% of covered services and 80% of durable medical equipment under both Parts A & B	Same as 1988	Intermittent skilled nursing care for up to 7 days a week for up to 38 days allowing for continuation of services under unusual circumstances; other services, —100% of covered services and 80% of durable medical equipment under both Parts A & B	Same as 1990

PART B

Medical Expense: Services of a Physician/Outpatient Services	80% of reasonable charges after an annual \$75 deductible	80% after annual \$75 deductible	80% of reasonable charges after \$75 annual deductible until out-of-pocket maximum is reached. 100% of reasonable charges are covered for remainder of calendar year	Same as 1990
Medical Supplies Other than Prescribed Drugs				

Blood	80% of costs except nonreplacement fees (blood deductible) for 1st 3 pints in each benefit period after \$75 deductible	Pays 80% of all costs except payment of deductible (equal to costs for first 3 pints) <u>each calendar year</u>	Same as 1989	Same as 1989
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Mammography Screening			80% of approved charge for elderly and disabled Medicare beneficiaries—exams available every other year for women 65 & over	Same as 1990
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APPENDIX A

Part B
MEDICARE BENEFITS IN

Service	1988	1989	1990	1991
Out-of-Pocket Maximum			\$1370 consisting of Part B \$75 deductible, Part B blood deductible and 20% coinsurance	\$1370—will be adjusted annually by secretary of Health and Human Services
Outpatient Prescription Drugs			There is a \$550 total deductible applicable to home I.V. drug and immunosuppressive drug therapies as noted below	Covered after \$600 deductible subject to 50% coinsurance
PART B				
Home I.V.-Drug Therapy			80% of I.V. therapy drugs subject to \$550 deductible (deductible waived if home therapy is a continuation of therapy initiated in a hospital)	80% of I.V. therapy drugs subject to standard drug deductible (deductible waived if home therapy is a continuation of therapy drugs initiated in a hospital)
Immunosuppressive Drug Therapy	80% of costs during 1st year following a covered organ transplant (no special drug deductible; only the regular Part B deductible)	Same as 1988	Same as 1988 for 1st year following covered transplant; 50% of costs during 2nd and following years (subject to \$550 deductible)	Same as 1990 (subject to \$600 deductible)
Respite Care Benefit			In-home care for chronically dependent individual covered for up to 80 hours after either the out-of-pocket limit or the outpatient drug deductible has been met	Same as 1990



APPENDIX A

6. Statement that the policy does or does not cover the following:
- (a) Private duty nursing;
 - (b) Skilled nursing home care costs (beyond what is covered by Medicare);
 - (c) Custodial nursing home care costs;
 - (d) Intermediate nursing home care costs;
 - (e) Home health care above number of visits covered by Medicare;
 - (f) Physician charges (above Medicare's reasonable charges);
 - (g) Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay);
 - (h) Care received outside the United States of America; and
 - (i) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care and examinations for the cost of eyeglasses or hearing aids.
7. A description of any policy provisions which exclude, eliminate, resist, reduce, limit, delay or in any other manner operate to qualify payments of the benefits described in paragraph 4., including conspicuous statements—
- (a) That the chart summarizing Medicare benefits only briefly describes the benefits; and
 - (b) That the Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations.
8. A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium.
9. The amount of premium for this policy.

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



APPENDIX B

NOTICE OF APPLICANT REGARDING
REPLACEMENT OF ACCIDENT
AND SICKNESS INSURANCE

According to *(your application) (information you have furnished)*, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by *(Company Name)* Insurance Company. Your new policy provides thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. If an insurer, health services corporation or health maintenance organization replaces a Medicare supplement policy, it may not deny benefits under the replacing policy to an insured on the basis that the benefits would be excluded as a preexisting condition, except to the extent that the replaced policy would have excluded the benefits as a preexisting condition.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded. The above Notice to Applicant was delivered to me on:

_____ (Date)

_____ (Applicant's Signature)



APPENDIX C

NOTICE OF APPLICANT REGARDING
REPLACEMENT OF ACCIDENT
AND SICKNESS INSURANCE

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

1. If an insurer, health services corporation or health maintenance organization replaces a Medicare supplement policy, it may not deny benefits under the replacing policy to be an insured on the basis that the benefits would be excluded as a preexisting condition, except to the extent that the replaced policy would have excluded the benefits as a preexisting condition.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. *(To be included only if the application is attached to the policy.)* If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to *(Company Name and Address)* within ten (10) days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)



APPENDIX D

(COMPANY NAME)

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

YOUR HEALTH CARE BENEFITS PROVIDED BY THE FEDERAL MEDICARE PROGRAM WILL CHANGE BEGINNING JANUARY 1, 1989. ADDITIONAL CHANGES WILL OCCUR ON MEDICAL BENEFITS IN FOLLOWING YEARS. THE MAJOR CHANGES ARE SUMMARIZED BELOW. THESE CHANGES WILL AFFECT HOSPITAL, MEDICAL AND OTHER SERVICES AND SUPPLIES PROVIDED UNDER MEDICARE. BECAUSE OF THESE CHANGES, YOUR MEDICARE SUPPLEMENT COVERAGE PROVIDED BY (COMPANY NAME) WILL CHANGE. ALSO, THE FOLLOWING OUTLINE BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ CAREFULLY!

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

Services	Medicare Benefits		Your Medicare Supplement Coverage	
	Medicare Now Pays Per Benefit Period	Medicare Will Pay Per Calendar Year	Your 1988 Coverage Per Benefit Period	Your Coverage Will Pay Per Calendar Year
MEDICARE PART A SERVICES AND SUPPLIES	First 60 days— All but \$540 61st to 90th day— All but \$135 a day 91st to 150th day— All but \$270 a day (if individual chooses to use 60 nonrenewable lifetime reserve days) Beyond 150th day— Nothing	Effective January 1, 1989 Unlimited number of hospital days after \$() deductible	Effective January 1, 1989 Your 1988 Coverage Per Benefit Period	Effective January 1, 1989 Your Coverage Will Pay Per Calendar Year
SKILLED NURSING FACILITY CARE	Requires a 3-day prior stay and enter the facility generally within 30 days after hospital discharge First 20 days— 100% of costs 21st through 100th day— All but \$67.50 a day Beyond 100 days— Nothing	There is no prior confinement requirement for this benefit First 8 days— All but \$() a day 9th through 150th day— 100% of costs Beyond 150 days— Nothing		



APPENDIX D

Services	Medicare Benefits		Your Medical Supplement Coverage	
	Medicare Now Pays Per Calendar Year	In 1989 Medicare Part B Pays The Same As In 1988	Your Policy Now Pays	Effective January 1, 1989 Your Policy Will Pay
MEDICARE PART B SERVICES AND SUPPLIES	50% of allowable charges (after \$75 deductible)	NOTE: Medicare benefits. change on January 1, 1990 as follows: 80% of allowable charges (after \$) deductible) until an annual Medicare Catastrophic limit is met. 100% of allowable charges for the remainder of the calendar year. The limit in 1990 is \$1370* and will be adjusted on an annual basis		
PRESCRIPTION DRUGS	Inpatient prescription drugs only	In 1989 Medicare covers inpatient prescription drugs only. Effective January 1, 1990 Per Calendar Year 80% of allowable charges for home intravenous (I.V.) therapy drugs and 50% of allowable charges for immunosuppressive drugs after (\$550 in 1990) calendar year deductible is met. Effective January 1, 1991 Per Calendar Year inpatient prescription drugs: 50% of allowable charges for all other outpatient prescription drugs after a \$600 calendar year deductible is met (the deductible will change). Coverage will increase to 60% of allowable charges in 1992 and to 80% of allowable charges from 1993 on.		



APPENDIX D

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

(ANY ADDITIONAL BENEFITS)

(Describe any coverage provisions changing due to Medicare modifications.)

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

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

(COMPANY OR FOR AN INDIVIDUAL POLICY—NAME OF AGENT) (ADDRESS/PHONE NUMBER)



APPENDIX E

(COMPANY NAME)

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

YOUR HEALTH CARE BENEFITS PROVIDED BY THE FEDERAL MEDICARE PROGRAM WILL CHANGE BEGINNING JANUARY 1, 1990. ADDITIONAL CHANGES WILL OCCUR IN MEDICAL BENEFITS IN FOLLOWING YEARS. THE MAJOR CHANGES ARE SUMMARIZED BELOW. THESE CHANGES WILL AFFECT HOSPITAL, MEDICAL AND OTHER SERVICES AND SUPPLIES PROVIDED UNDER MEDICARE. BECAUSE OF THESE CHANGES YOUR MEDICARE SUPPLEMENT COVERAGE PROVIDED BY (COMPANY NAME) WILL CHANGE. ALSO, THE FOLLOWING OUTLINE BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ THIS CAREFULLY:

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

Services	Medicare Benefits		Your Medicare Supplement Coverage	
	Medicare Now Pays Per Calendar Year	Effective January 1, 1990, Medicare Will Pay Per Calendar Year	Your Coverage Now Pays Per Calendar Year	Effective January 1, 1990 Your Coverage Will Pay Per Calendar Year
MEDICARE PART A SERVICES AND SUPPLIES	Unlimited number of hospital days after \$564 deductible			
SKILLED NURSING FACILITY CARE	There is no prior confinement require- ment for this benefit First 8 days— All but \$() a day 9th through 150th day— 100% of costs Beyond 150 days— Nothing			



APPENDIX E

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

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

(ANY ADDITIONAL BENEFITS)

(Describe any coverage provisions changing due to Medicare modifications.)

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

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

(COMPANY OR FOR AN INDIVIDUAL POLICY—NAME OF AGENT) (ADDRESS/PHONE NUMBER)



APPENDIX F

(COMPANY NAME)

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

YOUR HEALTH CARE BENEFITS PROVIDED BY THE FEDERAL MEDICARE PROGRAM WILL CHANGE BEGINNING JANUARY 1, 1991. ADDITIONAL CHANGES WILL OCCUR IN MEDICAL BENEFITS IN FOLLOWING YEARS. THE MAJOR CHANGES ARE SUMMARIZED BELOW. THESE CHANGES WILL AFFECT HOSPITAL, MEDICAL AND OTHER SERVICES AND SUPPLIES PROVIDED UNDER MEDICARE. BECAUSE OF THESE CHANGES YOUR MEDICARE SUPPLEMENT COVERAGE PROVIDED BY (COMPANY NAME) WILL CHANGE, ALSO. THE FOLLOWING OUTLINE BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ THIS CAREFULLY:

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

Services	Medicare Benefits		Your Medicare Supplement Coverage	
	Medicare Now Pays Per Calendar Year	Effective January 1, 1991 Medicare Will Pay Per Calendar Year	Your Coverage Now Pays Per Calendar Year	Effective January 1, 1991 Your Coverage Will Pay Per Calendar Year
MEDICARE PART A SERVICES AND SUPPLIES	Unlimited number of hospital days after \$() deductible			
SKILLED NURSING FACILITY CARE	There is no prior confinement require- ment for this benefit First 8 days-- All but \$() a day 9th through 150th day-- 100% of costs Beyond 150 days-- Nothing			



APPENDIX F

Services	Medicare Benefits		Your Medicare Supplement Coverage	
	Medicare Now Pays Per Calendar Year	Effective January 1, 1991 Medicare Will Pay Per Calendar Year	Your Coverage Now Pays Per Calendar Year	Effective January 1, 1991 Your Coverage Will Pay Per Calendar Year
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after \$75 deductible) until an annual Medicare Catastrophic Limit * is met. 100% of allowable charges for the remainder of the calendar year. The limit in 1991 is \$() and will be adjusted on an annual basis.			
PRESCRIPTION DRUGS	Inpatient prescription drugs. 50% of allowable charges for all other outpatient prescription drugs, until \$600 calendar year deductible is met.	Inpatient prescription drugs 60% of allowable charges for all other outpatient prescription drugs, until \$652 calendar year deductible is met. Coverage will increase to 80% of allowable charges from 1993 on, and deductible will be adjusted on an annual basis.		

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

(ANY ADDITIONAL BENEFITS)

(Describe any coverage provisions changing due to Medicare modifications.)

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

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

(COMPANY OR FOR AN INDIVIDUAL POLICY—NAME OF AGENT) (ADDRESS/PHONE NUMBER)



20 CSR 400-3.300 Medicare Supplement Loss Ratio Standards

(Rescinded August 28, 1994)

20 CSR 400-3.400 Model Rule to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Repeal of Medicare Catastrophic Coverage Act

PURPOSE: This rule assures the orderly implementation and conversion of Medicare supplement insurance benefits, coverage and premiums due to changes in the federal Medicare program.

Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.

(1) This rule shall apply to all Medicare supplement coverage delivered or issued for delivery in this state. The provisions of this rule shall have precedence over the provisions of any other regulation of this state to the extent necessary to assure that—

(A) Benefits do not duplicate benefits payable by Medicare;

(B) Benefits are adjusted to reflect changes in Medicare benefits;

(C) Applicants receive adequate notice and disclosure of changes in their Medicare supplement coverage; and

(D) Appropriate premium adjustments are made in a timely manner.

(2) Definitions. For the purposes of this rule—

(A) Applicant means—

1. In the case of an individual Medicare supplement policy or contract, the person who seeks to contract for insurance benefits; and

2. In the case of a group Medicare supplement policy or contract, the proposed certificate holder;

(B) Certificate means any certificate issued under a group Medicare supplement policy which has been delivered or issued for delivery in this state; and

(C) Medicare supplement policy means a group or individual policy of accident and health insurance, or a subscriber contract of

health service corporations, which is advertised, marketed or designed primarily to supplement coverage for hospital, medical or surgical expenses incurred by an insured person which are not covered by Medicare. This term does not include:

1. A policy or contract of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) or more employers or labor organizations, or a combination of them for employees or former employees or a combination of them, or for members or former members or a combination of them of the labor organization;

2. A policy or contract of any professional, trade or occupational association for its members, former or retired members or a combination of them if the association—

A. Is composed of individuals all of whom are actively engaged in the same profession, trade or occupation;

B. Has been maintained in good faith for purposes other than obtaining insurance; and

C. Has been in existence for at least two (2) years prior to the date of its initial offering of the policy or plan to its members; or

3. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions which are inconsistent with the requirements of sections 376.850—376.885, RSMo nor to Medicare supplement policies being issued to employees or members as additions to franchise plans in existence on July 1, 1982.

(3) Benefit Conversion Requirements.

(A) Effective January 1, 1990 no Medicare supplement insurance policy, contract or certificate in force in this state shall contain benefits which duplicate benefits provided by Medicare.

(B) Benefits eliminated by operation of the Medicare Catastrophic Coverage Act of 1988 transition provisions shall be restored.

(C) For Medicare supplement policies subject to the minimum standards adopted by the states pursuant to Medicare Catastrophic Coverage Act of 1988, the minimum benefits shall be—

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

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

4. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

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

6. Coverage for coinsurance amount of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible (seventy-five dollars (\$75)); and

7. Effective January 1, 1990 coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

(D) General Requirements.

1. No later than January 31, 1990, every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this state shall notify its policyholders, contract holders and certificate holders of modifications it has made to Medicare supplement insurance policies or contracts. This notice shall be in the format prescribed in Appendix A.

A. The notice shall include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement insurance policy or contract.

B. The notice shall inform each covered person as to when any premium adjustment due to changes in Medicare benefits will be effective.

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

D. The notice shall not contain or be accompanied by any solicitation.

2. No modifications to an existing Medicare supplement contract or policy shall be made at the time of or in connection with the notice requirements of this regulation except



to the extent necessary to accomplish the purpose of this regulation.

(4) Form and Rate Filing Requirements.

(A) As soon as practicable, but no longer than forty-five (45) days after the effective date of the Medicare benefit changes, every insurer, health care service plan or other entity providing Medicare supplement insurance or contracts in this state shall file with the Department of Commerce and Insurance, in accordance with the applicable filing procedures of this state—

1. Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts. Supporting documents as necessary to justify the adjustment shall accompany the filing; and

2. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare and to provide the benefits required by section (3). These riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or contract.

(B) Upon satisfying the filing and approval requirements of this state, every insurer, health care service plan or other entity providing Medicare supplement insurance in this state shall provide each covered person with any rider, endorsement or policy form necessary to make the adjustments outlined in section (4).

(C) Any premium adjustments shall produce an expected loss ratio under the policy or contract as will conform with minimum loss ratio standards for Medicare supplement policies and shall result in an expected loss ratio at least as great as that originally anticipated by the insurer, health care service plan or other entity for the Medicare supplement insurance policies or contracts. Premium adjustments may be calculated for the period commencing with Medicare benefits changes.

(5) Offer of Reinstitution of Coverage.

(A) Except as provided in subsection (5)(B), in the case of an individual who had in effect, as of December 31, 1988, a Medicare supplemental policy with an insurer (as a policyholder or, in the case of a group policy, as a certificate holder) and the individual terminated coverage under this policy before the date of the enactment of the repeal of the Medicare Catastrophic Coverage Act of 1988, the insurer shall—

1. Provide written notice no earlier than December 15, 1989 and no later than January 30, 1990 to the policyholder or certificate

holder (at the most recent available address) of the offer described in this rule; and

2. Offer the individual, during a period of at least sixty (60) days beginning not later than February 1, 1990, reinstatement of coverage (with coverage effective as of January 1, 1990) under terms which—

A. Do not provide for any waiting period with respect to treatment of preexisting conditions;

B. Provide for coverage which is substantially equivalent to coverage in effect before the date of the termination; and

C. Provide for classification of premiums which are 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 never terminated.

(B) An insurer is not required to make the offer under paragraph (5)(A)2. in the case of an individual who is a policyholder or certificate holder in another Medicare supplement policy as of January 1, 1990 if the individual is not subject to a waiting period with respect to treatment of a preexisting condition under the other policy.

(6) Requirements for New Policies and Certificates.

(A) Effective January 1, 1990 no Medicare supplement insurance policy, contract or certificate shall be delivered or issued for delivery in this state which provides benefits which duplicate benefits provided by Medicare. No Medicare supplement insurance policy, contract or certificate shall provide less benefits than those required under the existing Medicare Supplement Insurance Minimum Standards Model Act or Regulation except where duplication of Medicare benefits would result and except as required by transition provisions.

(B) General Requirements.

1. Within ninety (90) days of April 16, 1990, every insurer, health care service plan or other entity required to file its policies or contracts with this state shall file new Medicare supplement insurance policies or contracts which eliminate any duplication of Medicare supplement benefits with benefits provided by Medicare, which adjust minimum required benefits to changes in Medicare benefits and which provide a clear description of the policy or contract benefit.

2. The filing required under paragraph (6)(B)1. shall provide for loss ratios which are in compliance with all minimum standards.

3. Every applicant for a Medicare supplement insurance policy, contract or certificate shall be provided with an outline of cov-

erage which simplifies and accurately describes benefits provided by Medicare and policy or contract benefits along with benefit limitations.

(7) Filing Requirements for Advertising. Every insurer, health service plan or other entity providing Medicare supplement insurance or benefits in this state shall provide a copy of any advertisement intended for use in this state whether through written, radio or television medium to the director of insurance of this state for review or approval by the director to the extent it may be required under state law. This advertisement shall comply with all applicable laws of this state.

(8) Buyer's Guide. No insurer, health care service plan or other entity shall make use of or otherwise disseminate any buyer's guide or informational brochure which does not accurately outline current Medicare benefits and which has not been adopted by the director.

(9) Separability. If any provision of this rule or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of that provision to other persons or circumstances shall not be affected by it.

*AUTHORITY: sections 374.045 and 376.850—376.890, RSMo (1986). * This rule was previously filed as 4 CSR 190-14.620. Emergency rule filed Dec. 22, 1989, effective Jan. 1, 1990, expired April 15, 1990. Original rule filed Jan. 17, 1990, effective April 16, 1990. Non-substantive change filed Sept. 11, 2019, published Oct. 31, 2019.*

**Original authority: 374.045, RSMo (1967); 376.850, RSMo (1981), amended 1989; 376—376.864, RSMo (1989), amended 1992; 376.869—376.874, RSMo (1989), amended 1990, 1992; 376.879—376.889, RSMo (1989), amended 1992; and 376.890, RSMo (1981), amended 1988.*



APPENDIX A
(COMPANY NAME)

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

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

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

Services	Medicare Benefits		Your Medicare Supplement Coverage	
	In 1989 Medicare Pays Per Calendar Year	Effective January 1, 1990 Medicare Will Pay	In 1989 Your Coverage Pays	Effective January 1, 1990 Your Coverage Will Pay
MEDICARE PART A SERVICES AND SUPPLIES				
Inpatient Hospital Services	Unlimited number of hospital days after \$560 deductible	All but \$592 for first 60 days/benefit period		
Semiprivate Room & Board		All but \$148 a day for 61st—90th day/benefit period		
Misc. Hospital Services & Supplies, such as Drugs, X rays, Lab Tests & Operating Room		All but \$296 a day for 91st—150th day (if individual chooses to use 60 nonrenewable lifetime reserve days)		
BLOOD	Pays all costs except payment of deductible (equal to costs for first 3 pints) each calendar year. Part A blood deductible reduced to the extent paid under Part B	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period		
SKILLED NURSING FACILITY CARE	There is no prior confinement requirement for this benefit	100% of costs for first 20 days (after a 3-day prior hospital confinement)/benefit period		
	First 8 days— All but \$25.50 a day	All but \$74.00 a day for 21st—100th day/benefit period		



APPENDIX A

Services	Medicare Benefits		Your Medicare Supplement Coverage	
	<u>In 1989 Medicare Pays Per Calendar Year</u>	<u>Effective January 1, 1990 Medicare Will Pay</u>	<u>In 1989 Your Coverage Pays</u>	<u>Effective January 1, 1990 Your Coverage Will Pay</u>
	9th through 150th day— 100% of costs	Beyond 100 days Nothing/benefit period		
	Beyond 150 days— Nothing			
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after \$75 deductible)	80% of allowable charges (after \$75 deductible/ calendar year)		
PRESCRIPTION DRUGS	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after \$75 deductible/calendar year)	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after \$75 deductible/calendar year)		
BLOOD	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after \$75 deductible/ calendar year)	80% of costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after \$75 deductible/ calendar year)		

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

(Describe any coverage provisions changing due to Medicare modifications.)

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

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

(COMPANY OR FOR AN INDIVIDUAL POLICY—NAME OF AGENT) (ADDRESS/PHONE NUMBER)



20 CSR 400-3.500 Medicare Supplement Insurance Minimum Standards—December 31, 1990 to July 29, 1992

PURPOSE: This rule provides for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; facilitates public understanding and comparison of these policies; eliminates provisions contained in the policies which may be misleading or confusing in connection with the purchase of the policies or with the settlement of claims; and provides for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare by reason of age.

Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.

(1) Applicability and Scope. Except as otherwise specifically provided in sections (8) and (9), this rule shall—

(A) Apply to all Medicare supplement policies and subscriber contracts delivered or issued for delivery in this state on or after the effective date of this rule, December 31, 1990 and before July 30, 1992 except to the extent modified by 20 CSR 400-3.600(5);

(B) Apply to all certificates delivered or issued for delivery in this state under group Medicare supplement policies or subscriber contracts; and

(C) Not apply to a policy or contract of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) or more employers or labor organizations, or a combination of them, for employees or former employees or a combination of them, or for members or former members, or a combination of them, of the labor organizations.

(2) Definitions. For the purposes of this rule—

(A) Applicant means—

1. In the case of an individual Medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits; and

2. In the case of a group Medicare supplement policy or subscriber contract, the proposed certificate holder;

(B) Certificate means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy or subscriber contract; and

(C) Medicare supplement policy means a group or individual policy of accident and sickness insurance or a subscriber contract of a health service corporation or health maintenance organization (HMO) which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age. A contract or certificate of an HMO which provides coverage to Medicare enrollees in connection with the HMO's contract with the Health Care Financing Administration (HCFA) is not considered a Medicare supplement policy for the purposes of this regulation.

(3) Policy Definitions and Terms. No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy unless the policy or subscriber contract contains definitions or terms which conform to the requirements of this section.

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

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

2. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any Workers' Compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

(B) Benefit period or Medicare benefit period shall not be defined more restrictively than it is defined in the Medicare program.

(C) Convalescent nursing home, extended care facility or skilled nursing facility shall be defined in relation to its status, facilities and available services.

1. No definition shall be more restrictive than one requiring that it—

A. Be operated pursuant to law;

B. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

C. Provide continuous twenty-four (24)-hour-a-day nursing service by or under the supervision of a registered graduate professional nurse (RN); and

D. Maintain a daily medical record of each patient.

2. The definition may exclude—

A. Any home, facility or any part of a home or facility used primarily for rest;

B. A home or facility for the aged or for the care of drug addicts or alcoholics; or

C. A home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

(D) Health care expenses means expenses of HMOs associated with the delivery of health care services which are analogous to incurred losses of insurers. These expenses shall not include:

1. Home office or overhead costs;

2. Advertising costs;

3. Commissions and other acquisition costs;

4. Taxes;

5. Capital costs;

6. Administrative costs; or

7. Claims processing costs.

(E) Hospital may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

1. The definition of the term hospital shall not be more restrictive than one requiring that the hospital—

A. Operate pursuant to law;

B. Primarily and continuously engage in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

C. Provide twenty-four (24)-hour nursing service by or under the supervision of RNs.

2. The definition of the term hospital may state that the term shall not include:

A. Convalescent homes, convalescent, rest or nursing facilities;

B. Facilities primarily affording custodial, educational or rehabilitative care;

C. Facilities for the aged, drug addicts or alcoholics; or

D. Any military or veterans' hospital or soldiers' home or any hospital contracted for or operated by any national government or its agency for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis



where a legal liability exists for charges made to the individual for those services.

(F) Medicare shall be defined in the policy. Medicare may be substantially defined as The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 or Title I, Part I of P.L. 89-97, as enacted by the Eighty-Ninth Congress of the United States of America and popularly known as The Health Insurance for the Aged Act.

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

(H) Mental or nervous disorders shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease, or disorder of any kind.

(I) Nurses may be defined so that the description of nurse is restricted to a type of nurse, such as an RN, a licensed practical nurse (LPN) or a licensed vocational nurse (LVN). If the words nurse, trained nurse or registered nurse are used without specific instruction, then the use of those terms requires the insurer to recognize the services of any individual who qualified under the terminology in accordance with the applicable statutes or administrative rules of the State Board of Nursing.

(J) Physician may be defined by including words such as duly qualified physician or duly licensed physician. The use of these terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when those services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(K) Sickness shall not be defined to be more restrictive than the following: Sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any Workers' Compensation, occupational disease, employer's liability or similar law.

(4) Prohibited Policy Provisions.

(A) No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if that policy or subscriber contract limits or excludes coverage by type

of illness, accident, treatment or medical condition, except as follows:

1. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;

2. Mental or emotional disorders, alcoholism and drug addiction;

3. Illness, treatment or medical condition arising out of—

A. War or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or their auxiliary units;

B. Suicide or attempted suicide, while sane, or intentionally self-inflicted injury; or

C. Aviation;

4. Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when that service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;

5. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and its effect, where that interference is the result of or related to distortion, misalignment or subluxation of, or in, the vertebral column;

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

7. Dental care or treatment;

8. Eye glasses, hearing aids and examination for prescribing or fitting them;

9. Rest cures, custodial care, transportation and routine physical examinations; and

10. Territorial limitations outside the United States.

(B) Medicare supplement policies may not contain limitations or exclusions of the type enumerated in paragraph (4)(A)1., 2., 5., 7. or 10. that are more restrictive than those of Medicare. Medicare supplement policies may exclude coverage for any expense to the extent of any benefit available to the insured under Medicare.

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

(D) The terms Medicare supplement, Medigap and words of similar import shall not be used unless the policy is issued in compliance with this rule.

(5) Benefit Conversion Requirements.

(A) Effective January 1, 1990 no Medicare supplement insurance policy, contract or certificate in force in this state shall contain benefits which duplicate benefits provided by Medicare.

(B) Benefits eliminated by operation of the Medicare Catastrophic Coverage Act of 1988 transition provisions shall be restored.

(C) For Medicare supplement policies subject to the minimum standards adopted by the states pursuant to Medicare Catastrophic Coverage Act of 1988, the minimum benefits shall be—

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

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

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

4. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, of ninety percent (90%) of all Medicare Part A-eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

5. Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part A;

6. Coverage for the coinsurance amount of Medicare-eligible expenses under Part B regardless of hospital confinement subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible (seventy-five dollars (\$75)); and

7. Effective January 1, 1990, under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

(6) Minimum Standards. No insurance policy or subscriber contract may be advertised,



solicited or issued for delivery in this state as a Medicare supplement policy which does not meet the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards:

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

1. A Medicare supplement policy may not deny a claim for losses incurred more than six (6) months from the effective date of coverage for a preexisting condition. The policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage;

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

3. A Medicare supplement policy may not contain a provision which reduces benefit payments due to the existence of other Medicare supplement coverage. Coverage must provide that insureds are entitled to a return of all premiums paid for duplicate coverage with the same insurer;

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

5. 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 insurer solely on the grounds of deterioration of health;

6. An insurer shall neither cancel nor nonrenew an individual Medicare supplement policy or group certificate for any reason other than nonpayment of premium or material misrepresentation. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subsection (5)(D), the insurer shall offer certificate holders an individual Medicare supplement policy. The insurer shall

offer the certificate holder at least the following choices:

A. An individual Medicare supplement policy which provides for continuation of the benefits contained in the group policy;

B. An individual Medicare supplement policy which provides only benefits required to meet the minimum standards;

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

(I) The certificate holder conversion opportunities such as those described in subsections (6)(A) and (B); or

(II) The certificate holder continuation of coverage under the group policy, at the option of the group policyholder; and

D. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding insurer 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; and

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

(B) Minimum Benefit Standards.

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

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

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

4. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A-eligible expenses for hospitalization not covered by Medicare, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days.

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

federal regulations or already paid for under Part B.

6. Coverage for the coinsurance amount of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible (seventy-five dollars (\$75)) maximum benefit.

7. Effective January 1, 1990 coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

(7) Standards for Claims Payment.

(A) Every entity providing Medicare supplement policies or contracts shall comply with all provisions of Section 4081 of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203).

(B) Compliance with the requirements set forth in subsection (7)(A) must be certified on the Medicare supplement insurance experience reporting form.

(8) Loss Ratio Standards.

(A) For the purposes of this section, policy forms shall be deemed to comply with the loss ratio standards if—

1. For the most recent year, the ratio of the incurred losses to earned premiums for policies or certificates which have been in force for three (3) years or more is greater than or equal to the applicable percentages contained in this section; and

2. The expected losses in relation to premiums over the entire period for which the policy is rated comply with the requirements of this section. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

(B) Medicare supplement policies shall return to policyholders in the form of aggregate benefits under the policy, for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience or incurred health care expenses where coverage is provided by an HMO on a service rather than reimbursement basis, and earned premiums for the period and in accordance with accepted actuarial principles and practices at least—

1. Seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; and



2. Sixty percent (60%) of the aggregate amount of premiums earned in the case of individual policies.

(C) All filings of rates and rating schedules shall demonstrate that actual and expected losses in relation to premiums comply with the requirements of this section. In determining compliance with the loss ratio standards in section (8), the actual and expected incurred losses shall not include:

1. Loss adjustment expenses;
2. Active life reserves; and

3. Other claim reserves that would be found excessive or inconsistent with accepted actuarial standards.

(D) Every entity providing Medicare supplement policies in this state annually shall file its rates, rating schedules and supporting documentation on a form prescribed by the director including ratios of incurred losses-to-earned premiums by number of years of policy duration demonstrating that it is in compliance with the foregoing applicable loss ratio standards and that the period for which the policy is rated is reasonable in accordance with accepted actuarial principles and experience.

(E) Any change to a rate schedule must be filed and approved by the director. The rate change request must be accompanied by supporting documentation as set forth in subsection (8)(D).

(F) As soon as practicable, but prior to the effective date of Medicare benefit changes, every insurer, health care service plan or other entity providing Medicare supplement insurance or contracts in this state shall file with the director—

1. Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts. Supporting documents necessary to justify the adjustment shall accompany the filing, and every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this state pursuant to sections 376.850—376.890, RSMo shall make the premium adjustments necessary to produce an expected loss ratio under the standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the insurer, health care service plan or other entity for the Medicare supplement insurance policies or contracts. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described in this rule should be made with respect to a policy at any time other than upon its renewal date or anniversary date; and

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

(9) Filing Requirements for Out-of-State Group Policies. Every insurer providing group Medicare supplement insurance benefits to a resident of this state pursuant to sections 376.850—376.890, RSMo shall file a copy of the master policy and any certificate used in this state in accordance with the filing requirements and procedures applicable to group Medicare supplement policies issued in this state; however, no insurer shall be required to make a filing earlier than thirty (30) days after insurance was provided to a resident of this state under a master policy issued for delivery outside this state.

(10) Permitted Compensation Arrangements.

(A) An insurer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(B) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no less than three (3) renewal years.

(C) No entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing insurer on renewal policies or certificates if an existing policy or certificate is replaced unless benefits of the new policy or certificate are clearly and substantially greater than the benefits under the replaced policy.

(D) An agent writing a replacement policy shall complete a form substantially similar to that attached as Appendix B at the time of solicitation. The form shall be maintained in the company's underwriting file.



APPENDIX B Medicare Supplement Comparison

This comparison is to be used when you are soliciting a Medicare supplement policy to replace a Medicare supplement policy previously issued. It is for use by you and by the Home Office and should not be left with the insured:

Insured: _____

Policy Number: _____

Policy Being Replaced: _____

Name of Company: _____

Policy Number: _____ Plan Name or Policy Form: _____

	Policy Being Replaced		Replacing Policy	
Guaranteed Renewable	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pays Part A Deductible	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pays for Skilled Nursing Facility Stays Beyond 100 Days Per Benefit Period	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pays Even Though Nursing Facility Is Not Medicare-Approved	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pays for Intermediate Care Facility Stays	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pays for Levels of Care Other Than Skilled Care	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pays Part B Deductible	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pays Part B Benefit In Excess of 20% of Medicare-Approved Charges	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If "Yes", Describe	_____		Pays the difference between actual charges (not to exceed usual and customary charges) and Medicare approved charges	

Pays for Some Care Outside U.S.A.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Annual Premium	_____		_____	
Other Items	_____		_____	
	_____		_____	
	_____		_____	

Agent's Name: _____ Date: _____



(E) For purposes of this section, compensation includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including, but not limited to, bonuses, gifts, prizes, awards and finders' fees.

(11) Required Disclosure Provisions.

(A) General Rules.

1. Medicare supplement policies shall include a renewal or continuation provision. The language or specifications of the provision must be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy.

2. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy or is required to reduce or eliminate 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 issue, any rider or endorsement which increases benefits or coverage together with an increase in premium during the policy term must be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement insurance policies or if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, that premium charge shall be set forth in the policy.

3. A Medicare supplement policy which provides for the payment of benefits based on standards described as usual and customary, reasonable and customary, or words of similar import shall include a definition of those terms and an explanation of them in the policy's accompanying outline of coverage.

4. If a Medicare supplement policy contains any limitations with respect to preexisting conditions, those limitations must appear as a separate paragraph of the policy and be labeled as preexisting condition limitations.

5. Medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or certificate, or attached to it, 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. Insurers issuing accident and sickness policies, certificates or subscriber contracts which provide hospital or medical expense coverage on an expense-incurred or indemnity basis, other than incidentally, to a person(s) eligible for Medicare by reason of age shall provide to all applicants a Medicare Supplement Buyer's Guide in the form developed jointly by the National Association of Insurance Commissioners and the HCFA. Delivery of the Buyer's Guide shall be made whether or not the policies, certificates or subscriber contracts are advertised, solicited or issued as Medicare supplement policies as defined in this regulation. Except in the case of direct response insurers, delivery of the Buyer's Guide shall be made to the applicant at the time of application. Acknowledgment of receipt of the Buyer's Guide shall be obtained by the insurer. Direct response insurers shall deliver the Buyer's Guide to the applicant upon request but not later than at the time the policy is delivered.

(B) Notice Requirements.

1. As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this state shall notify its policyholders, contract holders and certificate holders of modifications it has made to Medicare supplement insurance policies or contracts in the format prescribed in Appendix A if no other format is prescribed by the director. This notice shall—

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

B. Inform each covered person as to when any premium adjustment is to be made due to changes in Medicare.

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

3. These notices shall not contain or be accompanied by any solicitation.

(C) Outline of Coverage Requirements for Medicare Supplement Policies.

1. Insurers issuing Medicare supplement policies or certificates for delivery in this state shall provide an outline of coverage to all applicants at the time application is made and, except for direct response policies, shall obtain an acknowledgment of receipt of 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 must accompany the policy or certificate when it is delivered. The substitute outline shall 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 paragraphs (11)(B)1. and 2. shall be in the following form:



(COMPANY NAME)
**OUTLINE OF MEDICARE
SUPPLEMENT COVERAGE
AND PREMIUM INFORMATION**

Use this outline to compare benefits and premiums among policies.

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

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

3) *(The appropriate notice in A. or B., below, shall be included:)*

A. *(for agents:)* Neither *(insert company's name)* nor its agents are connected with Medicare.

B. *(for direct responses:)* *(insert company's name)* is not connected with Medicare.

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

5) *(The following chart shall accompany the outline of coverage:)*



DESCRIPTION	THIS POLICY PAYS	YOU PAY
I. Minimum Standards		
SERVICE		
PART A		
INPATIENT HOSPITAL SERVICES:		
Semiprivate Room & Board		
Miscellaneous Hospital Services & Supplies, such as Drugs, X rays, Lab Tests & Operating Room		
BLOOD		
PART B		
MEDICAL EXPENSE:		
Services of a Physician/ Outpatient Services		
Medical Supplies Other Than Prescribed Drugs		
BLOOD		
MISCELLANEOUS		
Immunosuppressive Drugs		



DESCRIPTION	THIS POLICY PAYS	YOU PAY
II. Additional Benefits		
PART A		
PART A Deductible		
Private Rooms In-Hospital Private Nurses		
Skilled Nursing Facility Care		
PARTS A & B		
Home Health Services		
PART B		
PART B Deductible		
Medical Charges in Excess of Medicare Allowable Expenses (Percentage Paid)		
OUT-OF-POCKET MAXIMUM		
PRESCRIPTION DRUGS		
MISCELLANEOUS		
Respite Care Benefits		
Expenses Incurred in Foreign Country		
Other:		
TOTAL PREMIUM		

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

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



- 6) (Statement that the policy does or does not cover the following:
- A) Private duty nursing;
 - B) Skilled nursing home care costs (beyond what is covered by Medicare);
 - C) Custodial nursing home care costs;
 - D) Intermediate nursing home care costs;
 - E) Home health care above number of visits covered by Medicare;
 - F) Physician charges (above Medicare's reasonable charges);
 - G) Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay);
 - H) Care received outside the U.S.A.;
 - I) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for the cost of eyeglasses or hearing aids.)
- 7) (A description of any policy provisions which exclude, eliminate, resist, reduce, limit, delay or in any other manner operate to qualify payments of the benefits described in section 4 above, including conspicuous statements—
- A) That the chart summarizing Medicare benefits only briefly describes such benefits.
 - B) That the Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations.)
- 8) (A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium.)
- 9) (The amount of premium for this policy.) Drafting Note: The term certificate should be substituted for the word policy throughout the outline of coverage where appropriate.



(D) Notice Regarding Policies or Subscriber Contracts Which Are Not Medicare Supplement Policies. Any accident and sickness insurance policy or subscriber contract, other than a Medicare supplement policy; or a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 USC Section 1395), disability income policy; basic, catastrophic or major medical expense policy; single premium non-renewable policy or other policy identified in subsection (1)(B) of this rule, issued for delivery in this state to persons eligible for Medicare by reason of age shall notify insureds under the policy or subscriber contract that the policy or subscriber contract is not a Medicare supplement policy. This notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy or subscriber contract or, if no outline of coverage is delivered, to the first page of the policy, certificate or subscriber contract delivered to insureds. This notice shall be in no less than twelve (12)-point type and shall contain the following language: *THIS (POLICY, CERTIFICATE OR SUBSCRIBER CONTRACT) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CONTRACT)*. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company.

(12) Requirements for Application Forms and Replacement Coverage.

(A) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing these questions may be used.

1. Do you have another Medicare supplement insurance policy or certificate in force (including a health care service contract or HMD contract)?

2. Did you have another Medicare supplement policy or certificate in force during the last twelve (12) months?

A. If so, with which company?

B. If that policy lapsed, when did it lapse?

3. Are you covered by Medicaid?

4. Do you intend to replace any of your medical or health insurance coverage with this policy (certificate)?

(B) Agents shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

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

(C) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of accident and sickness coverage. One (1) copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the insurer. A direct response insurer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of accident and sickness coverage.

(D) The notice required by subsection (12)(C) for an insurer, other than a direct response insurer, shall be provided in substantially the following form:



**Notice to Applicant Regarding Replacement
Of Medicare Supplement Insurance**
(Insurance Company's Name and Address)
Save This Notice! It May Be Important To You In The Future

According to *(your application) (information you have furnished)*, you intend to lapse or otherwise terminate existing Medicare supplement insurance and replace it with a policy to be issued by *(Company Name)* Insurance Company. Your new policy provides thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision. **STATEMENT TO APPLICANT BY AGENT (BROKER OR OTHER REPRESENTATIVE):** *(Use additional sheets, as necessary.)* I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

- 1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy;
- 2) State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy;
- 3) If you are replacing existing Medicare supplement insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage;
- 4) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Agent, Broker or Other Representative) (Typed Name and Address of Agent or Broker)

The above "Notice to Applicant" was delivered to me on: _____
(Date)

(Applicant's Signature)



(E) The notice required by subsection (12)(C) for a direct response insurer shall be as follows:

**Notice to Applicant Regarding Replacement
Of Medicare Supplement Insurance**
(Insurance Company's Name and Address)
Save This Notice! It May Be Important To You In The Future

According to *(your application) (information you have furnished)*, you intend to lapse or otherwise terminate existing Medicare supplement insurance and replace it with the policy delivered herewith issued by *(Company Name)* Insurance Company. Your new policy provides thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

- 1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- 2) State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
- 3) If you are replacing existing Medicare supplement insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- 4) *(To be included only if the application is attached to the policy.)* If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to *(Company Name and Address)* within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)



(13) Filing Requirements for Advertising. Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits in this state shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the director of insurance of this state for review.

(14) Standards for Marketing.

(A) Every insurer, health care service plan or other entity marketing Medicare supplement insurance coverage in this state, directly or through its producers, shall—

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

2. Establish marketing procedures to assure that excessive insurance is not sold or issued;

3. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following: “Notice to buyer: This policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations”;

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

5. Establish auditable procedures for verifying compliance with subsection (14)(A).

(B) In addition to the practices prohibited in sections 375.930—375.948, RSMo, the following acts and practices are prohibited:

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

2. High pressure tactics—employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance; and

3. Cold lead advertising—making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that

contact will be made by an insurance agent or insurance company.

(15) Appropriateness of Recommended Purchase and Excessive Insurance.

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

(B) Any sale of Medicare supplement coverage which will provide an individual more than one (1) Medicare supplement policy or certificate is prohibited; provided, however, that additional Medicare supplement coverage may be sold if, when combined with that individual’s health coverage already in force, it would insure no more than one hundred percent (100%) of the individual’s actual medical expenses covered under the combined policies.

(16) Reporting of Multiple Policies.

(A) On or before March 1, every insurer or other entity providing Medicare supplement insurance coverage in this state shall report the following information for every individual resident of this state for which the insurer or entity has in force more than one (1) Medicare supplement insurance policy or certificate:

1. Policy and certificate number; and
2. Date of issuance.

(B) The items set forth in paragraphs (16)(A)1. and 2. must be grouped by individual policyholder.

(17) Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy for similar benefits to the extent the time was spent under the original policy.

(18) Separability. If any provision of this rule or its application to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected by it.



APPENDIX A
(COMPANY NAME)

Notice Of Changes In Medicare And Your Medicare SUPPLEMENT COVERAGE—1990

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

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

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



Services	Medicare Benefits		Your Medicare Supplement Coverage	
	<u>In 1989 Medicare Pays Per Calendar Year</u>	<u>Effective January 1, 1990 Medicare Will Pay</u>	<u>In 1989 Your Coverage Pays</u>	<u>Effective January 1, 1990 Your Coverage Will Pay</u>
SKILLED NURSING FACILITY CARE	There is no prior confinement requirement for this benefit	100% of costs for first 20 days (after a 3-day prior hospital confinement)/benefit period		
	First 8 days— All but \$25.50 a day	All but \$74 a day for 21st—100th day/benefit period		
	9th—150th day— 100% of costs	Beyond 100 days— Nothing/benefit period		
	Beyond 150 days— Nothing			
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after \$75 deductible)	80% of allowable charges (after \$75 deductible/calendar year)		
PRESCRIPTION DRUGS	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after \$75 deductible/calendar year)	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after \$75 deductible/calendar year)		
BLOOD	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after \$75 deductible/calendar year)	80% of costs except nonreplacement fees (blood deductible) for first 3 pints (after \$75 deductible/calendar year)		

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

(Describe any coverage provisions changing due to Medicare modifications.)

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

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

(COMPANY OR FOR AN INDIVIDUAL POLICY—NAME OF AGENT) (ADDRESS/PHONE NUMBER)



AUTHORITY: sections 374.045.1(2), RSMo 1986 and 376.869, RSMo Supp. 1990. This rule was previously filed as 4 CSR 190-14.625. Original rule filed July 17, 1990, effective Dec. 31, 1990. Emergency amendment filed July 6, 1992, effective July 30, 1992, expired Nov. 26, 1992. Amended: Filed July 6, 1992, effective April 8, 1993.*

**Original authority: 374.045.1, RSMo 1967 and 376.869, RSMo 1989, amended 1992.*

20 CSR 400-3.600 Medicare Supplement Insurance Minimum Standards Act
(Rescinded June 30, 1999)

AUTHORITY: sections 374.045, 376.864.3, 376.864.4, 376.864.5, 376.869, 376.879, and 376.886, RSMo Supp. 1997. Emergency rule filed July 6, 1992, effective July 30, 1992, expired Nov. 26, 1992. Original rule filed July 6, 1992, effective April 8, 1993. Emergency amendment filed April 17, 1996, effective April 28, 1996, expired Oct. 24, 1996. Amended: Filed May 1, 1996, effective Oct. 30, 1996. Amended: Filed Dec. 1, 1997, effective June 30, 1998. Rescinded: Filed Oct. 15, 1998, effective June 30, 1999.

20 CSR 400-3.650 Medicare Supplement Insurance Minimum Standards Act

PURPOSE: This rule provides for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies, facilitates public understanding and comparison of such policies, eliminates provisions contained in the policies which may be misleading or confusing in connection with the purchase of the policies or with the settlement of claims and provides for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

(1) Applicability and Scope.

(A) Except as otherwise specifically provided in sections (5), (13), (14), (17), and (24), this rule shall apply to—

1. All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this rule; and

2. All certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state.

(B) This rule shall not apply to a policy or contract of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) or more employers or labor organizations, or combination

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

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

(2) Definitions. For purposes of this rule—

(A) "Applicant" means—

1. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

2. In the case of a group Medicare supplement policy, the proposed certificate holder;

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

(C) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy;

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

(E) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days;

(F)

1. "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

A. A group health plan;

B. Health insurance coverage;

C. Part A or Part B of Title XVIII of the Social Security Act (Medicare);

D. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;

E. Chapter 55 of Title 10 *United States Code* Civilian Health and Medical Program of the Uniformed Services (CHAMPUS);

F. A medical care program of the Indian Health Service or of a tribal organization;

G. A state health benefits risk pool;

H. A health plan offered under Chapter 89 of Title 5 *United States Code* (Federal Employees Health Benefits Program);

I. A public health plan as defined in federal regulation; and

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

2. "Creditable coverage" shall not include one (1) or more, or any combination of, the following:

A. Coverage only for accident or disability income insurance, or any combination thereof;

B. Coverage issued as a supplement to liability insurance;

C. Liability insurance, including general liability insurance and automobile liability insurance;

D. Workers' compensation or similar insurance;

E. Automobile medical payment insurance;

F. Credit-only insurance;

G. Coverage for on-site medical clinics; and

H. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

3. "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

A. Limited scope dental or vision benefits;

B. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

C. Such other similar, limited benefits as are specified in federal regulations.

4. "Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

A. Coverage only for a specified disease or illness; and

B. Hospital indemnity or other fixed indemnity insurance.

5. "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate, or contract of insurance:

A. Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

B. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, *United States Code*; and

C. Similar supplemental coverage provided to coverage under a group health plan;

(G) "Director" means the director of the Department of Commerce and Insurance of this state;

(H) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits, including, but not limited to those defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act);

(I) "Insolvency" means when an issuer,



licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile;

(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;

(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;

(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;

(M) "Medicare 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 Advantage medical savings account; and

3. Medicare Advantage private fee-for-service plans;

(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 Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under section 1833(a)(1)(A) of the Social Security Act;

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

(P) "Pre-standardized Medicare supplement benefit plan," "Pre-standardized benefit plan," or "Pre-standardized plan" means a group or individual policy of Medicare supplement insurance issued prior to July 30, 1992;

(Q) "Qualified actuary" means a member of the American Academy of Actuaries;

(R) "1990 Standardized Medicare supplement benefit plan," "1990 Standardized benefit plan," or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after July 30, 1992, and with an effective date for coverage prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured;

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

(T) "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.

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

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

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

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

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

(D) "Health care expenses" means, for purposes of section (15), expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

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

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

(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.

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

(I) "Sickness" shall not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law.

(4) Policy Provisions.

(A) Except for permitted preexisting condition clauses as described in paragraph (5)(A)1. and paragraph (6)(A)1. of this rule, no policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

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



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

(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 cer-

tificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

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 non-renew 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.

(B) Minimum Benefit Standards.

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

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

4. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days.

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

6. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible.

7. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless



replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

(6) Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After July 30, 1992, and with an Effective Date for Coverage Prior to June 1, 2010. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 30, 1992, and with an effective date for coverage prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(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, copayment, or coinsurance amounts. 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 non-renew the policy solely on the ground of health status of the individual.

B. The issuer shall not cancel or non-renew 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 reinstated 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 reinstated (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.

D. Reinstatement 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, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(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.

8. If an issuer makes a written offer to the Medicare supplement policyholders or certificate holders of one (1) or more of its plans, to exchange during a specified period



from his or her 1990 Standardized plan (as described in section (8) of this regulation) to a 2010 Standardized plan (as described in section (9) of this regulation), the offer and subsequent exchange shall comply with the following requirements:

A. An issuer need not provide justification to the director if the insured replaces a 1990 Standardized policy or certificate with an issue age rated 2010 Standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the director;

B. The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage;

C. An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six (6) months to any added benefits contained in the new 2010 Standardized policy or certificate not contained in the exchanged policy; and

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

(B) Standards for Basic (Core) Benefits Common to 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 eligi-

ble 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.

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, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(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 (\$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 out-

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

C. 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.

(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) Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date of Coverage on or After June 1, 2010. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010, remain subject to the requirements of section (6) of this regulation.

(A) General Standards. The following standards apply to Medicare supplement policies



and certificates and are in addition to all other requirements of this regulation.

1. A 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, copayment, or coinsurance amounts. 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 non-renew the policy solely on the ground of health status of the individual.

B. The issuer shall not cancel or non-renew 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 (7)(A)5.E. of this regulation, 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 section.

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 (7)(A)5.C. of this regulation; 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.

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

cyholder 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.

D. Reinstitution of coverages as described in subparagraphs (7)(A)7.B. and (7)(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 that is substantially equivalent to 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 Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M, and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic “core” package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

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 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,



or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

6. Hospice care. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

(C) Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by section (9) of this regulation:

1. Medicare Part A Deductible. Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period;

2. Medicare Part A Deductible. Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period;

3. Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;

4. Medicare Part B Deductible. Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

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

6. 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.

(8) Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After July 30, 1992, and with an Effective Date for Coverage Prior to June 1, 2010.

(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 subsection (6)(B) of this rule.

(B) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in paragraph (6)(C)11. and in section (11) of this rule.

(C) Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit plans "A" through "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), (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.

(D) An issuer may use, in addition to the benefit plan designations required in subsection (8)(C), other designations to the extent permitted by law.

(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 a 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)(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 premi-

ums, 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.

(G) New or Innovative Benefits. An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. 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 that 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.

(9) Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates with an Effective Date for Coverage on or After June 1, 2010. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates with an effective date for coverage before June 1, 2010, remain subject to the requirements of section (6) of this regulation.

(A) *Reserved*

1. An issuer shall make available to each prospective policyholder and certificate hold-

er a policy form or certificate form containing only the basic (core) benefits, as defined in subsection (7)(B) of this regulation.

2. If an issuer makes available any of the additional benefits described in subsection (7)(C), or offers standardized benefit Plans K or L (as described in paragraphs (9)(E)8. and 9. of this regulation), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to the basic (core) benefits as described in paragraph (9)(A)1. above, a policy form or certificate form containing either standardized benefit Plan C (as described in paragraph (9)(E)3. of this regulation) or standardized benefit Plan F (as described in paragraph (9)(E)5. of this regulation).

(B) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in subsection (9)(F) and in sections (10) and (11) of this regulation.

(C) Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit plans listed in this subsection and conform to the definitions in section (2) of this regulation. Each benefit shall be structured in accordance with the format provided in subsections (7)(B) and (7)(C) of this regulation; or, in the case of Plans K or L, in paragraphs (9)(E)8. or 9. of this regulation and list the benefits in the order shown. For purposes of this section, “structure, language, and format” means style, arrangement, and overall content of a benefit.

(D) In addition to the benefit plan designations required in subsection (C) of this section, an issuer may use other designations to the extent permitted by law.

(E) Make-up of 2010 Standardized Benefit Plans.

1. Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in subsection (7)(B) of this regulation.

2. Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible as defined in paragraph (7)(C)1. of this regulation.

3. Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as



defined in paragraphs (7)(C)1., 3., 4., and 6. of this regulation, respectively.

4. Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit (as defined in subsection (7)(B) of this regulation), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 3., and 6. of this regulation, respectively.

5. Standardized Medicare supplement (regular) Plan F shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of 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 (7)(C)1., 2., 4., 5., and 6., respectively.

6. Standardized Medicare supplement Plan F With High Deductible shall include only the following: One hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in subparagraph (9)(E)6.B.

A. The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of 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 (7)(C)1., 3., 4., 5., and 6., of this regulation, respectively.

B. The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by regular Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be one thousand five hundred dollars (\$1,500) and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services 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).

7. Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part

A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 3., 5., and 6., respectively. Effective January 1, 2020, the standardized benefit plan described in paragraph (10)(A)4. of this rule (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

8. Standardized Medicare supplement Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

A. Part A Hospital Coinsurance sixty-first through ninetieth days: 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. Part A Hospital Coinsurance ninety-first through the one hundred fiftieth day: 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. Part A Hospitalization After One Hundred Fifty (150) Days: 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 (9)(E)8.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 (9)(E)8.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 (9)(E)8.J.;

G. Blood: 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 regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

H. Part B Cost Sharing: Except for coverage provided in subparagraph (9)(E)8.I., 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 (9)(E)8.J.;

I. Part B Preventive Services: 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. Cost Sharing After Out-of-Pocket Limits: 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 adjustment specified by the secretary of the U.S. Department of Health and Human Services.

9. Standardized Medicare supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

A. The benefits described in subparagraphs (9)(E)8.A., B., C., and I.;

B. The benefit described in subparagraphs (9)(E)8.D., E., F., G., and H., but substituting seventy-five percent (75%) for fifty percent (50%); and

C. The benefit described in subparagraph (9)(E)8.J; but substituting two thousand dollars (\$2,000) for four thousand dollars (\$4,000).

10. Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)2., 3., and 6. of this regulation, respectively.

11. Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred



percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 3., and 6., of this regulation, respectively, with copayments in the following amounts:

A. The lesser of twenty dollars (\$20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and

B. The lesser of fifty dollars (\$50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(F) 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 standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

(10) Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to Individuals Newly Eligible for Medicare on or after January 1, 2020. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020 remain subject to the requirements of section (9) of this

rule.

(A) Benefit Requirements. The standards and requirements of section (9) shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

1. Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in paragraph (9)(E)3. of this rule but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible;

2. Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in paragraph (9)(E)5. of this rule but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible;

3. Standardized Medicare supplement benefit Plan C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020;

4. Standardized Medicare supplement benefit Plan F with High Deductible is redesignated as Plan G with High Deductible and shall provide the benefits contained in paragraph (9)(E)6. of this rule but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible; and

5. The reference to Plans C or F contained in paragraph (9)(A)2. is deemed a reference to Plans D or G for purposes of this section (10).

(B) Applicability to Certain Individuals. This section (10) applies only to individuals that are newly eligible for Medicare on or after January 1, 2020—

1. By reason of attaining age 65 on or after January 1, 2020; or

2. By reason of entitlement to benefits under Part A pursuant to section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020.

(C) Guaranteed Issue for Eligible Persons. For purposes of subsection (13)(E) of this rule, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F with High Deductible) shall be deemed to be a reference to Medicare supplement Policy D or G (including G with High Deductible) respec-

tively that meets the requirements of this section (10).

(D) Offer of Redesignated Plans to Individuals other than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in paragraph (A)4. of this section (10) may be offered to any individual who was eligible for Medicare prior to January 1, 2020 in addition to the standardized plans described in subsection (9)(E) of this rule.

(11) Medicare Select Policies and Certificates.

(A) *Reserved*

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

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

(B) For the purposes of this section—

1. “Complaint” means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers;

2. “Grievance” means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers;

3. “Medicare Select issuer” means an issuer offering, or seeking to offer, a Medicare Select policy or certificate;

4. “Medicare Select policy” or “Medicare Select certificate” mean respectively a Medicare supplement policy or certificate that contains restricted network provisions;

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

6. “Restricted network provision” means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers; and

7. “Service area” means the geographic area approved by the director within which an issuer is authorized to offer a Medicare Select policy.

(C) The director may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, if the director finds that the issuer has satisfied all of the requirements of this rule.

(D) A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the director.



(E) A Medicare Select issuer shall file a proposed plan of operation with the director in a format prescribed by the director. The plan of operation shall contain at least the following information:

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

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

B. The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either—

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

(II) To make appropriate referrals;

C. There are written agreements with network providers describing specific responsibilities;

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

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

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

3. A description of the grievance procedure to be utilized;

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

A. The formal organizational structure;

B. The written criteria for selection, retention, and removal of network providers; and

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

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

6. Copies of the written information proposed to be used by the issuer to comply with subsection (I) of this section; and

7. Any other information requested by

the director.

(F) *Reserved*

1. A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the director prior to implementing the changes. Changes shall be considered approved by the director after thirty (30) days unless specifically disapproved.

2. An updated list of network providers shall be filed with the director at least quarterly.

(G) A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if—

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

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

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

(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.

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

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

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

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

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

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

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

6. The issuer shall report no later than each March thirty-first to the director regarding its grievance procedure. The report shall be in a format prescribed by the director and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of such grievances.

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

(M) *Reserved*

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 (1) or more significant benefits not included in the



Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services, or coverage for Part B excess charges.

(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 (1) or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services, or coverage for Part B excess charges.

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

(12) Open Enrollment.

(A) An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six- (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.

(B) 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 that policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant under age sixty-five (65), if:

1. The application for the policy or certificate is submitted prior to or during the six- (6-) month period beginning with the first day of the first month during which the applicant becomes enrolled for benefits under Medicare Part B, without regard to age, after June 30, 1998; or

2. The applicant was enrolled for benefits under Medicare Part B without regard to age on or prior to June 30, 1998, and the application for a policy or certificate is submitted during the six- (6-) month period beginning with June 30, 1998.

(C) *Reserved*

1. If an applicant qualifies under either subsection (12)(A) or (B), submits an application during the applicable time period referenced in those subsections, and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

2. If the applicant qualifies under either subsection (12)(A) or (B), submits an application during the applicable time period referenced in those subsections, and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subsection.

(D) Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants to whom an issuer is required to issue a policy or certificate of Medicare supplement insurance under this section.

(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 (16)(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.

(F) Each Medicare supplement carrier shall actively market Medicare supplement insurance during the open enrollment periods described in subsection (B) of this section.

(G) No Medicare supplement carrier shall directly or indirectly engage in the following activities respecting persons enrolled in Medicare Part B by reason of disability during the open enrollment periods described in subsection (B) of this section:

1. Encouraging or directing such persons to refrain from filing an application for Medicare supplement insurance because of the health status, claims experience, receipt of health care, or medical condition of the person; and

2. Encouraging or directing such persons to seek coverage from another carrier because of the health status, claims experience, receipt of health care, or medical condition of the person.



(H) No Medicare supplement carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an insurance producer that provides for or results in the compensation paid to an 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 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 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 insurance producer with the Medicare supplement insurance carrier.

(K) Denial by a Medicare supplement insurance carrier of an application for coverage made during either of the open enrollment periods described in subsection (B) of this section shall be in writing and state the specific reason or reasons for the denial.

(L) Except as provided in subsection (C) of this section and section (24), subsections (A) and (B) of this section shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

(13) Guaranteed Issue for Eligible Persons.

(A) Guaranteed Issue.

1. Eligible persons are those individuals described in subsection (B) of this section who seek to enroll under the policy during the period specified in subsection (C) of this section, and who submit evidence of the date of termination, 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 (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 all such supplemental health benefits to the individual, or the individual leaves the plan;

2. The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is sixty-five (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 certification of the organization or plan has been terminated;

B. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

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

D. The individual demonstrates, in accordance with guidelines established by the secretary, that—

(I) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(II) The organization, 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

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

3. Reserved

A. The individual is enrolled with—

(I) An eligible organization under a contract under section 1876 of the Social Security Act (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) of the Social Security Act (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 (13)(B)2.;

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

A. Reserved

(I) Of the insolvency of the issuer or bankruptcy of the non-issuer 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, 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. Reserved

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

B. The subsequent enrollment under subparagraph (13)(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



at age sixty-five (65), enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment;

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

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 is 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 is terminated.

4. In the case of an individual described in paragraph (B)2., subparagraph (B)4.B. or (B)4.C., or 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.

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 (13)(B)5.

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 (13)(B)6.

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.

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

1. Paragraphs (13)(B)1., 2., 3., and 4. is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L offered by any issuer;

2. Reserved

A. Subject to subparagraph B., paragraph (13)(B)5. is the same Medicare supple-

ment 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. Paragraph (13)(B)6. shall include any Medicare supplement policy offered by any issuer;

4. Paragraph (13)(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

5. Paragraph (13)(B)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, if available, or, if not so available due to changes in the Medicare supplement plan designs, a policy with a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L.

(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.

(14) Standards for Claims Payment.

(A) An issuer shall comply with section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, P.L. No. 100-203) by—

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

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

3. Paying the participating physician or supplier directly;

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

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

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

(B) Compliance with the requirements set forth in subsection (A) above shall be certified on the Medicare supplement insurance experience reporting form.

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

(A) Loss Ratio Standards.

1. *Reserved*

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. 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.

3. For purposes of applying paragraph (A)1. of this section and paragraph (C)3. of section (16) 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 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, included herein, 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 January 1, 2006. The first report shall be due by May 31, 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.

(C) Annual Filing of Premium Rates. An issuer of Medicare supplement policies and certificates issued before or after the effective date of April 3, 1993, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the director, in accordance with the applicable filing procedures of this state—

1. *Reserved*

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

B. An issuer shall make premium adjustments necessary to produce an expected



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

C. If an issuer fails to make premium adjustments acceptable to the director, the director may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio required by this section;

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

(D) Public Hearings. The director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of April 8, 1993, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

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

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

(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.

(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.

(D) *Reserved*

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 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.

(E) *Reserved*

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. 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:

A. 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

B. 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 (16)(H)11. The director may approve a change to the differential which is in the public interest.

(F) *Reserved*

1. Except as provided in paragraph (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 (15) 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.

(G) *Reserved*

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 (16)(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 (16)(E)3.

(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 (15)(C) or a change of premium rates for a plan under subsection (16)(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 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 (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 (16)(D) for standardized Medicare supplement plans marketed after June 30, 1998, must demonstrate compliance with the requirements of subsection (12)(E). The "weighted average aged premium," must be recalculated for each filing using current data, unless the issuer demonstrates compliance under subparagraph (12)(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 (16)(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 (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 (15)(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 (15)(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.

(17) Permitted Compensation Arrangements.

(A) An issuer or other entity may provide commission or other compensation to an 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.

(B) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

(C) No issuer or other entity shall provide compensation to its insurance producers and no 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.

(D) For purposes of this section, “compensation” includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards, and finder’s fees.

(18) 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. *Reserved*

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 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.

(B) Notice Requirements.

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

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

B. Inform each policyholder or certificate holder as to when any premium

adjustment is to be made due to changes in Medicare.

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

3. The notices shall not contain or be accompanied by any solicitation.

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

(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 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.



Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: a ✓ means 100% of the benefit is paid.

Benefits	Plans available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G ¹	K	L	M	N	C	F
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply ³	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in [2019] ²					[\$5,560] ²	[\$2,780] ²				

¹ Plans F and G also have a high deductible option which require first paying a plan deductible of [\$2300] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

² Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

³ Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to \$20 for some office visits and up to a \$50 co-payment for emergency room visits that do not result in an inpatient admission.



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.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. [This paragraph shall not appear after June 1, 2011.]

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

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

RIGHT TO RETURN POLICY [Boldface Type]

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

POLICY REPLACEMENT [Boldface Type]

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

NOTICE [Boldface Type]

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

[for agents:]

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

[for direct 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 regulation. An issuer may use additional benefit plan designations on these charts pursuant to subsection (9)(D) of this regulation.]

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