

# DEPARTMENT OF REGULATORY AGENCIES

## Division of Insurance

### 3 CCR 702-4

#### LIFE, ACCIDENT AND HEALTH

##### Emergency Regulation 20-E-14

##### MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT POLICIES

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## **Section 1      Authority**

This emergency regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-18-103(2), 10-18-104, 10-18-106 and 10-1-109, C.R.S.

## **Section 2      Scope and Purpose**

The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; to provide for full disclosure in the sale of accident and sickness insurance coverage to persons eligible for Medicare; and to comply with the mandate of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) which prohibit the sale of Medicare supplement benefit policies that cover Medicare Part B deductibles to "newly eligible" Medicare beneficiaries defined as those individuals who become eligible for Medicare due to age, disability or end-stage renal disease, on or after January 1, 2020.

The Division of Insurance finds, pursuant to § 24-4-103(6)(a), C.R.S., that immediate adoption of this regulation is imperatively necessary for the preservation of public health, safety, or welfare to ensure that this regulation complies with current federal requirements, and to ensure that consumers whose Medicare Cost Plans are being discontinued prior to January 1, 2021, are able to enroll in an appropriate Medicare supplement plan, is imperative to preserve the health of the citizens of Colorado. Therefore, compliance with the requirements of § 24-4-103, C.R.S., would be contrary to the public interest. This emergency regulation replaces Colorado Insurance Regulation 4-3-1 in its entirety.

## **Section 3      Applicability**

- A. Except as otherwise specifically provided in Sections 7, 12, 13, 16 and 21, this regulation shall apply to:
  - 1. All Medicare supplement policies delivered or issued for delivery in this state; and
  - 2. All certificates issued under group Medicare supplement policies or subscriber contracts, which certificates have been delivered or issued for delivery in this state.
- B. This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.
- C. Except as specifically provided by statute, Medicare supplement policies are regulated under §§ 10-18-101 to 109, C.R.S., and any regulations promulgated there under. Nothing in this regulation shall be construed as conflicting with statutes that are not specifically applicable to Medicare supplement insurance.

## **Section 4      Definitions**

- A. "Applicant" means, for the purposes of this regulation:

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, for the purposes of this regulation, when a Medicare Advantage organization that is not an issuer has filed, or has filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

C. "Certificate" means, for the purposes of this regulation, any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

D. "Certificate form" means, for the purposes of this regulation, the form on which the certificate is delivered or issued for delivery by the issuer.

E. "Continuous period of creditable coverage" means, for the purposes of this regulation, 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 for voluntary terminations and six (6) months for involuntary terminations (other than non payment of premium or fraud).

F. Creditable Coverage

1. "Creditable coverage" means, for the purposes of this regulation, 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 (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; and
  - j. A health plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).
2. "Creditable coverage" shall not include, for the purposes of this regulation, one 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 sites; and
- h. Other similar insurance coverage, specified in federal regulations, under which benefits for medical coverage are secondary or incidental to other insurance benefits.

3. "Creditable coverage" shall not include, for the purposes of this regulation, 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, for the purposes of this regulation, the following benefits if offered as independent, non-coordinated 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, for the purposes of this regulation, 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. "Employee welfare plan" means, for the purposes of this regulation, a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

H. "Health care expenses" mean, for the purposes of this regulation, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of issuers.

- I. "Insolvency" means, for the purposes of this regulation, 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 court of competent jurisdiction in the issuer's state of domicile.
- J. "Issuer" includes, for the purposes of this regulation, insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.
- K. "Medicare" means, for the purposes of this regulation, "The Health Insurance for the Aged Act," Title XVIII of the federal "Social Security Act" as amended. This regulation does not cover amendments to this statute that were promulgated later than the effective date of this regulation.
- L. "Medicare Advantage plan" means, for the purposes of this regulation, a plan of coverage for health benefits under Medicare Part C as defined in the definition of Medicare Advantage plan in 42 U.S.C. Section 1395w-28(b)(1). Included are:
  - 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.
- M. "Medicare supplement policy" means, for the purposes of this regulation, a group or individual policy of sickness and accident insurance or a subscriber contract of a hospital and medical service association or a health maintenance organization, 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.
- N. "Nurse" means, for the purposes of this regulation, a "graduate nurse", "practical nurse", "trained practical nurse", "licensed vocational nurse", "licensed practical nurse", "registered nurse" or "registered professional nurse" as defined under § 12-38-103, C.R.S.
- O. "Pre-standardized Medicare supplement benefit plan" or "pre-standardized plan" mean, for the purposes of this regulation, a group or individual policy of Medicare supplement insurance issued prior to May 1, 1992.
- P. "1990 Standardized Medicare supplement benefit plan" or "1990 plan" mean, for the purposes of this regulation, a group or individual policy of Medicare supplement insurance issued on or after May 1, 1992 and prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after April 30, 1992 which are not replaced by the issuer at the request of the insured.
- Q. "2010 Standardized Medicare supplement benefit plan," "2010 standardized benefit plan," or "2010 plan" mean, for the purposes of this regulation, a group or individual policy of Medicare supplement insurance issued with an effective date for coverage issued on or after June 1, 2010.

- R. "Policy form" means, for the purposes of this regulation, the form on which the policy is delivered or issued for delivery by the issuer.
- S. "Public health plan" means, for the purposes of this regulation, any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.
- T. "Secretary" means, for the purposes of this regulation, the Secretary of the U.S. Department of Health and Human Services.

## **Section 5 Policy Definitions and Terms**

No policy or certificate may be identified in this state as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms that conform to the requirements of this Section 5.

- 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. Such definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.
- B. "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined by Medicare.
- C. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined by Medicare.
- D. "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 by Medicare.
- E. "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 federal "Social Security Act," as amended by the Social Security amendments of 1965, and as 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.
- F. "Medicare-eligible expenses" shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.
- G. "Physician" shall not be defined more restrictively than as defined by Medicare.
- H. "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.

## **Section 6 Policy Provisions**

- A. Except for permitted preexisting conditions clauses as described in Section 7.A.1., Section 8.A.1., and Section 8.1.A.1. of this regulation, no policy or certificate may be identified as a Medicare supplement policy if such 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 that duplicate benefits provided by Medicare.
- D. Rules for Prescription Drugs
  - 1. Subject to Sections 7.A.4., 5. and 7. and 8.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 Medicare 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 Medicare Part D; 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.
- E. All Medicare supplement insurance policies shall provide for a refund of unearned premium, when the policy is replaced by another Medicare supplement carrier or given a request for cancellation by the insured.

## **Section 7 Minimum Benefit Standards for Pre-Standardized Medicare Supplement Benefit Plan Policies or Certificates issued for Delivery Prior to May 1, 1992**

No policy or certificate may be identified 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 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 shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.
2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare shall 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 "non-cancelable," "guaranteed renewable," or "non-cancelable 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 canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.
5. Replacement, Termination, and Nonrenewal
  - a. Except as authorized by the Commissioner, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.
  - b. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Section 7.A.5.d., the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:
    - (1) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and
    - (2) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Section 8.1.B. of this regulation.
  - c. If membership in a group is terminated, the issuer shall:
    - (1) Offer the certificate holder such conversion opportunities as are described in Section 7.A.5.b.; or
    - (2) 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 benefits period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits shall 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 Section 7.A.

B. Minimum Benefit Standards

1. Coverage of Medicare Part A eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.
2. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount.
3. Coverage of Medicare Part A 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 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 Medicare Part B;
6. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system (PPS), the copayment amount, of Medicare-eligible expenses under Medicare Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible.
7. 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 Medicare Part A, subject to the Medicare deductible amount.

**Section 8      Minimum Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or after May 1, 1992 and with an Effective Date for Coverage Prior to June 1, 2010**

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after May 1, 1992 and with an effective date for coverage prior to

June 1, 2010. No policy or certificate may be identified 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 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 shall 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 and:
    - a. The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual;
    - b. The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation;
    - c. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8.A.5.e., the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder):
      - (1) Provides for continuation of the benefits contained in the group policy; or
      - (2) Provides for such benefits as otherwise meets the requirements of this Section 8.A.
    - 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:
      - (1) Offer the certificate holder the conversion opportunity described in Section 8.5.c.; or
      - (2) 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 Section 8.A.5.
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 shall not be considered in determining continuous loss.
7. Suspension and reinstatement of Medicare supplement policies shall be in accordance with the following:
  - 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 (Medicaid), but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance.
  - b. If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstated (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificate holder provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.
  - 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 § 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 policyholder provides notice of the loss of coverage within ninety (90) days after the date of the loss and pays the premium attributable to the period as of the date of the termination of such entitlement.
  - d. Reinstatement of such coverages as described in Section 8.A.7. b. and c.:
    - (1) Shall not provide for any waiting period with respect to treatment of preexisting conditions;
    - (2) Shall provide for resumption of coverage which is substantially equivalent to coverage in effect before the date of such suspension. If

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

(3) 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 or more of its plans, to exchange during a specified period from his or her 1992 standardized plan as described in Section 9 of this regulation to a 2010 standardized plan as described in Section 9.1. of this regulation, the offer and subsequent exchange shall comply with the following requirements:

a. An issuer need not provide justification to the Commissioner if the insured replaces a 1992 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 shall be filed with the Commissioner.

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:

(1) Shall not apply new preexisting condition limitations or a new contestability period to the new policy for those benefits contained in the exchanged 1992 standardized policy or certificate of the insured; but

(2) May apply pre-existing condition limitations of no more than six (6) months to any added benefits only if this fact is clearly disclosed in the offer to the consumer.

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 All 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 thereof:

1. Coverage of Medicare Part A eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

2. Coverage of Medicare Part A 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 inpatient hospital 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 PPS rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 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; and
5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a PPS, the copayment amount, of Medicare-eligible expenses under Medicare 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 9 of this regulation:

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 21st day through the 100th 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 differences 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 outpatient prescription drug benefit may have been 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 have been 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 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
  - a. Coverage for the following preventive health services not covered by Medicare:
    - (1) An annual clinical preventive medical history and physical examination that may include tests and services from Section 8.C.9.b. and patient education to address preventive health care measures.; and
    - (2) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.
  - b. 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; and
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 the purposes of this benefit, the following definitions shall apply:
    - (1) "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.
    - (2) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses' registry.
    - (3) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.
    - (4) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a 24-hour period of services provided by a care provider is one (1) visit.

b. Coverage Requirements and Limitations

- (1) At-home recovery services provided must be primarily services, which assist in activities of daily living.
- (2) 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.
- (3) 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 week;
  - (e) Care furnished on a visiting basis in the insured's home;
  - (f) Services provided by a care provider as defined in Section 8.C.10.a.(2);
  - (g) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded; and
  - (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:

- (1) Home care visits paid for by Medicare or other government programs; and
- (2) Care provided by family members, unpaid volunteers or providers who are not care providers.

D. Standards for Medicare Supplement Benefit 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 Medicare Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

- b. Coverage of one hundred percent (100%) of the Medicare Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th 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 PPS rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 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 Section 8.D.1.j.;
- e. Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st through the 100th 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 Section 8.D.1.j.;
- f. Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in Section 8.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 regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Section 8.D.1.j.;
- h. Except for coverage provided in Subparagraph i. below, coverage for the fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Medicare Part B deductible until the out-of-pocket limitation is met as described in Section 8.D.1.j.;
- i. Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Medicare 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. This amount may be indexed each year by the appropriate inflation adjustment 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 Sections 8.D.1.a., b., c. and i.;
- b. The benefits described in Sections 8.D.1.d., e., f., g., and h., but substituting seventy-five percent (75%) for fifty percent (50%); and
- c. The benefit described in Sections 8.D.1.j. but substituting the amount specified by the Secretary of the U.S. Department of Health and Human Services.

**Section 8.1      Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or after June 1, 2010**

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be identified as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1992 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 before June 1, 2010 remain subject to the requirements of Section 8 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 shall 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 and:
    - a. The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and
    - b. The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.
    - c. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8.1.A.5.e., the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder):
      - (1) Provides for continuation of the benefits contained in the group policy; or
      - (2) Provides for such benefits as otherwise meets the requirements of this Section 8.1.A.
  - 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:

- (1) Offer the certificate holder the conversion opportunity described in Section 8.1.A.5.c.; or
  - (2) 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 shall not be considered in determining continuous loss.
- 7. Suspension and reinstatement of Medicare supplement policies shall be in accordance with the following:
  - 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 (Medicaid), but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance.
  - b. If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstated (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificate holder provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.
  - 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 § 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 policyholder provides notice of the loss of coverage within ninety (90) days after the date of the loss.
  - d. Reinstatement of such coverages as described in Sections 8.1.A. 7.b. and c.:
    - (1) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

- (2) Shall provide for resumption of coverage which is substantially equivalent to coverage in effect before the date of such suspension; and
- (3) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

B. Standards for Basic ("Core") Benefits Common to All Medicare Supplement 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 Medicare Part A eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
- 2. Coverage of Medicare Part A 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 inpatient hospital 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 PPS rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 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 PPS, the copayment amount, of Medicare-eligible expenses under Medicare Part B regardless of hospital confinement, subject to the Medicare Part B deductible; and
- 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 9.1 of this regulation:

- 1. Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amounts per benefit period;
- 2. Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amounts per benefit period;
- 3. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post hospital skilled nursing facility care eligible under Medicare Part A;

4. Medicare Part B Deductible: Coverage for all 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 charge 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 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.

**Section 9      Minimum Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery After April 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 Section 8.B. 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 Sections 9.G. and 24 of this regulation.
- 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 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Section 8.B.8.C. or 8.D. and list the benefits in the order shown in this section. For the 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 Section 9 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 Section 8.B. of this regulation;
  2. Standardized Medicare Supplement Benefit Plan B shall include only the following: The basic "core" benefits as defined in Section 8.B. of this regulation, plus the Medicare Part A deductible as defined in Section 8.C.1.;
  3. Standardized Medicare Supplement Benefit Plan C shall include only the following: The basic "core" benefits as defined in Section 8.B. of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in Sections 8.C.1, 2., 3., and 8., respectively;

4. Standardized Medicare Supplement Benefit Plan D shall include only the following: The basic "core" benefits as defined in Section 8.B. of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in Sections 8.C.1., 2., 8., and 10., respectively;
5. Standardized Medicare Supplement Benefit Plan E shall include only the following: The basic "core" benefits as defined in Section 8.B. of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care benefit defined in Sections 8.C.1., 2., 8., and 9., respectively;
6. Standardized Medicare Supplement Benefit Plan F shall include only the following: The basic "core" benefits as defined in Section 8.B. of this regulation, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.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 Section 8.B. of this regulation, 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 Sections 8.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, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10);
8. Standardized Medicare Supplement Benefit Plan G shall include only the following: The basic "core" benefits as defined in Section 8.B. of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in Sections 8.C.1., 2., 4., 8., and 10., respectively;
9. Standardized Medicare Supplement Benefit Plan H shall consist of only the following: The basic "core" benefits as defined in Section 8.B. of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit and medically necessary emergency care in a foreign country as defined in Sections 8.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 basic "core") benefits as defined in Section 8.B. of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, Basic Outpatient Prescription Drug Benefit, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in Sections 8.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 basic "core" benefits as defined in Section 8.B. of this regulation, plus the Medicare Part

A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, Preventive Medical Care and the at-home recovery benefit as defined in Sections 8.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; and

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 "basic "core" benefits as defined in Section 8.B. of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit medically necessary emergency care in a foreign country, preventive medical care benefit and the at-home recovery benefit as defined in Sections 8.C.1., 2., 3., 5., 7., 8., 9., and 10., respectively. The annual high deductible Plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan J policy, and shall be in addition to any other specific benefit deductibles, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10). The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

F. Make-up of Medicare Supplement benefit plans K and L:

1. Standardized Medicare supplement benefit plan K shall consist of only those benefits described in Section 8.D.1.
2. Standardized Medicare supplement benefit plan L shall consist of only those benefits described in Section 8.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 which is consistent with the goal of simplification of Medicare supplement policies. The innovative benefit shall not include an outpatient prescription drug benefit.

**Section 9.1 Standard Medicare Supplement Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or after June 1, 2010**

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be identified as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of Section 9.

A. Standard plans issued on or after June 1, 2010 shall comply with the following standards:

1. An issuer shall make available to each prospective policyholder and certificate holder a policy or certificate form containing only the basic "core" benefits, as defined in Section 8.1.B. of this regulation.

2. If an issuer makes available any of the additional benefits described in Section 8.1.C. or offers standardized benefit Plans K or L (as described in Sections 9.1.E.8. and 9. of this regulation) then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic "core" benefits as described in Section 9.1.A.1., a policy form or certificate form containing either standardized benefit Plan C (as described in Section 9.1.E.3. of this regulation or standardized benefit Plan F (as described in Section 9.1.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 Sections 9.1.F. and 24 of this regulation.

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 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 8.1.B. and 8.1.C. of this regulation; or, in the case of plans K or L, in Sections 9.1.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 Section 9.1.C., 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 described in Section 8.1.B. of this regulation.
2. Standardized Medicare Supplement Benefit Plan B shall include only the following: The basic "core" benefits as defined in Section 8.1.B. of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible as defined in Section 8.1.C.1. of this regulation.
3. Standardized Medicare Supplement Benefit Plan C shall include only the following: The basic "core" benefits as defined in Section 8.1.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 Sections 8.1.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" benefits as defined in Section 8.1.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 Sections 8.1.C.1., 3., and 6., of this regulation respectively.
5. Standardized Medicare Supplement Benefit Plan F shall include only the following: The basic "core" benefits as defined in Section 8.1.B. of this regulation, plus 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 Sections 8.1.C.1., 3., 4., 5., and 6., of this regulation, respectively.
6. 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 set forth in Section 9.1.E.6.b.:

- a. The basic "core" benefits as defined in Section 8.1.B. of this regulation, plus 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 Sections 8.1.C.1., 3., 4., 5., and 6., 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 the regular Plan F policy, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be annual and shall be adjusted annually 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-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" benefits as defined in Section 8.1.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 Excess Charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1.C.1., 3., 5., and 6., respectively. Effective January 1, 2020, the standardized benefit plans described in Section 9.2 A.4. of this regulation (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 Benefit Plan K is mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and shall include only the following:

- a. Medicare Part A Hospital Coinsurance 61st to 90<sup>th</sup> days: Coverage of one hundred percent (100%) of the Part A inpatient hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;
- b. Medicare Part A Hospital Coinsurance, 91st to 150th days: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through 150th day in any Medicare benefit period;
- c. Medicare Part A Hospitalization after 150 Days: Upon exhaustion of the Medicare inpatient hospital 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 PPS rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 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 Section 9.1.E.8.j.;
- e. Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th 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 Section 9.1.E.8.;

- 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 Section 9.1.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 Section 9.1.E.8.j.;
- h. Medicare Part B Cost Sharing: Except for coverage provided in Section 9.1.E.8.j., 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 Section 9.1.E.8.j.;
- i. Medicare 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 Medicare 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. This amount may be 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 Benefit 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 Sections 9.1.E.8. a., b., c., and i. of this regulation;
- b. The benefits described in Sections 9.1.E. 8. d., e., f., g., and h. but substituting seventy-five percent (75%) for fifty percent (50%); and
- c. The benefit described in Sections 9.1.E. 8. j. of this regulation, but substituting the amount specified by the Secretary of the U.S. Department of Health and Human Services.

10. Standardized Medicare Supplement Benefit Plan M shall include only the following: The basic "core" benefits as defined in Section 8.1.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 Sections 8.1.C.2., 3., and 6. of this regulation, respectively.

11. Standardized Medicare Supplement Benefit Plan N shall include only the following: The basic "core" benefits as defined in Section 8.1.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 Sections 8.1.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 Commissioner, 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.

**Section 9.2 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 to be 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 shall 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 and 9.1.

- A. Benefit Requirements. The standards and requirements of Section 9.1 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 Section 9.1.E.3. of this regulation 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 Section 9.1.E.5. of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.
  - 3. Standardized Medicare supplement benefit Plans C, F, and F with High Deductible shall 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 Section 9.1.E.6. of this regulation 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.
  - 5. The reference to Plans C or F contained in Section 9.1.A.2. is deemed a reference to Plans D or G for purposes of this section.

B. Applicability to Certain Individuals. This Section 9.2 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 Medicare 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 Section 11.E., 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 Plan F With High Deductible) shall be deemed to be a reference to Medicare supplement policy D or G (including G With High Deductible), respectively, that meet the requirements of Section 9.2.A.

D. Offer of Redesignated Plans to Individuals Other Than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in Section 9.2.A.4. above may be offered to any individual who was eligible for Medicare prior to January 1, 2020 in addition to the standardized plans described in Section 9.1.E. of this regulation.

## **Section 10 Open Enrollment**

A. No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such 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 an individual is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subsection regardless of 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 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.

C. Conditions under which benefits may be reduced or excluded:

1. If the applicant qualifies under either Section 10.A. or 10.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 Section 10.A. or 10.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 Commissioner 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.
- E. An issuer must demonstrate compliance with this section for each plan, type, and form level permitted under Section 14.C. by:
  - 1. Charging a premium rate for persons under age sixty-five (65) that does not exceed the highest available premium rate for each plan, type, and form level;
  - 2. Making a premium adjustment for persons under age sixty-five (65) that is equal to the premium adjustment for persons over age sixty-five (65); or
  - 3. Special Case. If the filing is to introduce a new product to Colorado, the issuer shall charge a premium rate for persons under age sixty-five (65) that is equal to 1.5 times the age sixty-five (65) premium rate.
- F. Each Medicare supplement issuer shall actively market Medicare supplement insurance during the open enrollment periods described in Section 10.B.
- G. No Medicare supplement issuer shall directly or indirectly engage in the following activities in respect to persons enrolled in Medicare Part B by reason of disability during the open enrollment periods described in Section 10.B.:
  - 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/or
  - 2. Encouraging or directing such persons to seek coverage from another issuer because of the health status, claims experience, receipt of health care or medical condition of the person.
- H. Issuer may not vary the commission paid on the sale or renewal of a Medicare supplement insurance policy due to any factor, except first year or renewal status, including, but not limited to, the plan marketed, the insured's age, health status, claims experience, location of residence, receipt of health care, or medical condition. However, issuers may pay a different commission on a policy transferred to a different producer for servicing purposes, following the initial sale, or on a policy sold over the internet, providing there is no variation for any other reason.
- I. A Medicare supplement carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale, during the open enrollment periods described in Section 10.B., of a Medicare supplement insurance policy or certificate.
- J. No Medicare supplement insurance issuer shall terminate, fail to renew or limit its contract or agreement of representation with a 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 Section 10.B. for Medicare supplement insurance, placed by a producer with the Medicare supplement insurance issuer.
- K. Except as provided in Section 10.C. and Section 22, Sections 10.A. and 10.B. 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.

## **Section 11      Guaranteed Issue for Eligible Persons**

### **A.      Guaranteed Issue**

1.      Eligible persons are those individuals described in Section 11.B. who seek to enroll under the policy during the period specified in Section 11.C., and who submit evidence of the date of termination, or 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 Section 11.E. 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 examples:

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 is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan;
2.      The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, 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 § 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:
  - a.      The certification of the organization or plan under this part has been terminated;
  - 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 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 an area;
  - d.      The individual demonstrates, in accordance with guidelines established by the Commissioner, that:
    - (1)     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

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

e. The individual meets such other exceptional conditions as the Commissioner may provide.

3. The individual is enrolled with any of the following and the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 11.B.2.:

a. An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);

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

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

d. An organization under a Medicare Select Policy.

4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases due to:

a. The insolvency of the issuer or bankruptcy of the non-issuer organization;

b. Other involuntary termination of coverage or enrollment under the policy;

c. The issuer of the policy substantially violating a material provision of the policy; or

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

5. Terminations and Reenrollments

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 Medicare Part C, any eligible organization under a contract under Section 1876 of the Social Security Act (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 Section 11.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 § 1851 e) of the federal Social Security Act);

6. The individual, upon first becoming eligible for benefits under Medicare Part A, enrolls in a Medicare Advantage plan under Medicare Part C, 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 Medicare 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 Section 11.E.5.; or
8. An individual who is currently enrolled in both Medicare and Medicaid who loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

C. Guaranteed Issue Time Periods

1. In the case of an individual described in Section 11.B.1., whose cancellation was not due to nonpayment of premium or fraud, the guaranteed issue period begins on the later of:
  - a. 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
  - b. The date that the applicable coverage terminates or ceases and ends six (6) months thereafter if they leave the plan involuntarily or sixty three (63) days if voluntary;
2. In the case of an individual described in Sections 11.B.2., 3., 5. or 6. whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date the individual receives notice of termination and six (6) months after the date the applicable coverage terminated;
3. In the case of an individual described in Section 11.B.4.a., the guaranteed issue period begins on the earlier of:
  - a. The date that the individual receives notice of termination, a notice of the issuer's bankruptcy or insolvency, or other similar notice if any, and
  - b. The date that the applicable coverage is terminated and ends on the date that is six (6) months after the date the coverage is terminated;
4. In the case of an individual described in Sections 11.B.2., 4.b., 4.c., 5. or 6. who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the disenrollment effective date and ends on the date that is sixty-three (63) days after the disenrollment effective date;
5. In the case of an individual described in Section 11.B.7., the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day (60) period immediately preceding the initial Medicare Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and
6. In the case of an individual described in Section 11.B. but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of

the voluntary disenrollment and ends on the date that is sixty-three (63) days after the effective date. If the termination is involuntary (not due to nonpayment of premium or fraud), the guaranteed issue period begins on the effective date of involuntary termination and ends on the date that is six (6) months after the involuntary termination date.

D. Extended Medigap Access for Interrupted Trial Periods

1. In the case of an individual described in Section 11.B.5. (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Section 11.B.5.a. is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 11.B.5.;
2. In the case of an individual described in Subsection 11.B.6. (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Section 11.B.6. 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 Subsection 11.B.6.; and
3. For the purposes of Section 11.B.5. and 6., no enrollment of an individual with an organization or provider described in Subsection 11.B.5.a., or with a plan or in a program described in Section 11.B.6., may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

E. Products to Which Eligible Persons are Entitled.

1. Medicare supplement policies classified as Plan C and F (including Plan F with a high deductible) are no longer available to individuals who become eligible for Medicare on or after January 1, 2020.
2. The Medicare supplement policy to which eligible persons are entitled under Sections 11.B.1., 2., 3. and 4., is a Medicare supplement policy which has a benefit package classified as:
  - a. For individuals who were initially eligible for Medicare before January 1, 2020, Plan A, B, C, F (including Plan F with a high deductible), K or L, offered by any issuer; or
  - b. For individuals who were initially eligible for Medicare on or after January 1, 2020, Plan A, B, D, G (including Plan G with a high deductible), K or L, offered by any issuer; or
  - c. For individuals who are eligible pursuant to Section 11.B.3.a., with a plan termination date of December 31, 2020 who also meet the requirements of Section 11.E. 2. a., shall be allowed the additional option of choosing a Plan D or G (including Plan G with a high deductible).
3. Reenrollments
  - a. Subject to Section 11.B.5.b., is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Section 11.E.2.

- 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:
  - (1) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or
  - (2) At the election of the policyholder, a Plan A, B, C, F (including Plan F with a high deductible), K or L policy that is offered by the any issuer.
- 4. Section 11.B.6. shall include any Medicare supplement policy offered by any issuer.
- 5. Section 11.B.7. is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including Plan 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 drug coverage.

F. **Notification Provisions**

- 1. At the time of an event described in Section 11.B. causing an individual to lose 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 Section 11.A. Such notice shall be communicated contemporaneously with the notification of termination.
- 2. At the time of an event described in Section 11.B. causing an individual to cease 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 Section 11.A. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

**Section 12 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, Pub. L., No. 100-203) by:
  - 1. Accepting notice from a Medicare carrier on dually assigned claims submitted by participating providers 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 the notice;
  - 2. Notifying the participating provider or supplier and the beneficiary of the payment determination;
  - 3. Paying the participating provider 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 requirement set forth in Section 12.A. above shall be certified on the Medicare supplement insurance experience reporting form.

### **Section 13     Loss Ratio Standards and Refund or Credit of Premium**

A. Loss Ratio Standards

1. Lifetime Requirements
  - a. Indemnity Forms: 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 forms:
    - (1) Group Policies: At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or
    - (2) Individual Policies: At least sixty-five (65%) percent of the aggregate amount of premiums earned in the case of individual policies.
  - b. HMOs: Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:
    - (1) Home office and overhead costs;
    - (2) Advertising costs;
    - (3) Commissions and other acquisition costs;
    - (4) Taxes;
    - (5) Capital costs;
    - (6) Administrative costs; and
    - (7) Claims processing costs.
2. Historical Requirement (Standardized Forms): All filings of rates and rating schedules shall demonstrate that the ratio of incurred claims to earned premiums from inception of the form(s) to the last date of the experience period (historical loss ratio) comply with the requirements of Section 13.A.1. or provide acceptable justification as to why this historical requirement has not yet been met. If this requirement has not been demonstrated, the rate filing will be disapproved.

3. Future Period Requirement (Standardized Forms): All filings of proposed rate revisions shall also demonstrate that the anticipated loss ratio for each year of the entire future period for which the revised rates are computed to provide coverage can be expected to meet or exceed the loss ratio requirements from Section 13.A.1., or provide acceptable justification as to why this future period requirement has not been met. All assumptions underlying the projected future experience should be clearly supported. These include lapse, mortality, morbidity, etc. If this requirement has not been demonstrated, the rate filing will be disapproved.
4. For purposes of applying Sections 13.A.1. and 14.C.3. only, group certificates issued as a result of solicitations of individuals through the mail or by mass media advertising (including both print and broadcast advertising) shall be required to comply with the group Medicare supplement requirements.
5. Pre-Standardized Plans: For policies issued prior to May 1, 1992, the ratio of incurred claims to earned premiums (loss ratio) shall comply with all of the following requirements. If compliance with these requirements is not demonstrated, the rate filing will be disapproved.
  - a. Historical Requirement: All filings of rates and rating schedules shall demonstrate that the ratio of incurred claims to earned premiums from inception of the form(s) to the last date of the experience period (historical loss ratio) is greater than or equal to the originally filed loss ratio for the form(s), or provide acceptable justification as to why this historical requirement has not yet been met;
  - b. Historical Requirement Since April 1, 1996: All filings of rates and rating schedules shall demonstrate that the historical loss ratio since April 1, 1996 meets the appropriate loss ratio requirement from Section 13.A.1. as applied to the actual experience beginning with April 1, 1996 to the last date of the experience period;
  - c. Future Period Requirement: All filings of proposed rate revisions shall also demonstrate that the anticipated loss ratio for each year of the entire future period for which the revised rates are computed to provide coverage can be expected to meet or exceed the loss ratio requirements from Section 13.A.1. All assumptions underlying the projected future experience should be clearly supported. These include lapse, mortality, morbidity, etc.; and
  - d. Lifetime Requirement: All filings of rates and rating schedules shall also demonstrate that the ratio of incurred claims to earned premiums from inception of the form(s) to the last date of the entire future period for which the revised rates are computed to provide coverage can be expected to meet or exceed the originally filed loss ratio for the form(s). All assumptions underlying the projected future experience should be clearly supported. These include lapse, mortality, morbidity, etc.
6. Experience Data
  - a. Each Medicare supplement issuer shall file the 2010 standardized plans concurrently with the 1990 standardized plans. The rates for the 1990 plans and the 2010 plans shall be submitted in separate filings via SERFF (the NAIC's System for Electronic Rates and Forms Filing).
  - b. Each Medicare supplement issuer shall provide pooled experience of all 1990 standardized plans with the experience of all the 2010 standard plans of the

same letter and type as well as the experience for just the 1990 standardized plans or 2010 standardized plans separately in each filing.

- c. Issuers are allowed to vary rate increases between the 1990 plans and the 2010 plans of the same letter, as long as they follow the guidelines listed above; that is, as long as the adjustments within the pool are on a revenue neutral basis and as long as it results in the 1990 plan rates to move closer to the 2010 plan rates.
7. Rate filings for each plan, type, and form level permitted under Section 10.C. for standardized plans marketed after February 1, 2005, must demonstrate compliance with the requirements of Section 10.E.

B. Refund or Credit Calculation

1. An issuer shall collect and file with the Commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type of 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 subsection, policies or certificates issued prior to May 1, 1992, the issuer shall make the refund or credit calculation separately for all individual policies combined and all other group policies combined for experience after April 1, 1996..
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 the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual Filing of Premium Rates

An issuer of Medicare supplement policies and certificates issued in this state shall file, on an annual basis, its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the Commissioner in accordance with the filing requirements and procedures prescribed by the Commissioner. 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 Commissioner in accordance with the applicable filing procedures of this state:

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

2. An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the 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.
3. If an issuer fails to make premium adjustments acceptable to the Commissioner, the Commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.
4. 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 certificates.

D. **Public Hearings**

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

**Section 14 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 Commissioner in accordance with filing requirements and procedures prescribed by the Commissioner.
- 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 Commissioner 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 Commissioner in accordance with the filing requirements and procedures prescribed by the Commissioner.
- D. Issuers have the option of offering Medicare supplement plans on an attained age basis, issue age basis, or a dual rating basis. Issuers are required to provide adequate information to consumers so an informed choice can be made on their Medicare Supplement purchases.

If an issuer elects to offer dual rating methodologies, the issuer must comply with the following requirements:

1. Under individual insurance policies, the individual policyholder should have a choice as to whether to elect an issue age or attained age rating methodology. For a group policy, it is the group policyholder, not the certificate holder, who has this choice. However, both methodology options shall be presented to each individual or group policyholder prior to purchase.

2. Issuers shall develop materials that disclose both rating methodologies and also include an explanation of how they differ both in the near term and the long term. Producers shall carefully explain to the prospective individual or group policyholder the difference between the two (2) rating methodologies and explain their rights to switch from one rating methodology to another. All marketing material and/or advertisements shall be submitted to the Division of Insurance for review and must demonstrate the differences between the two (2) rating methodologies.
3. The producer commissions shall be the same for both methodologies. The dollar level of first-year commissions shall be no more than twice the dollar level of second-year commissions and shall not vary based on the rating methodology elected by the individual or group policyholder. Renewal commissions for years two (2) through six (6) may be a constant dollar amount that does not vary based on the rating methodology or must be defined as a constant percentage of the issue age premium.
4. Individual and group policyholders should be allowed to switch from an attained age rating methodology to an issue age rating methodology. However, individuals or group policyholders shall not be allowed to switch from an issue age rating methodology to an attained age rating methodology.
5. The attained age and issue age rates shall be demonstrated to be actuarially equivalent and to prospectively achieve the loss ratio requirements.

E. Limitations on the number of forms that may be approved for standardized Medicare supplement benefit plans.

1. Except as provided in Section 14.E.2., 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 Commissioner, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:
  - a. The inclusion of new or innovative benefits;
  - b. The addition of either direct response or 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 Section 14.E., a "type" means an individual policy or a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

F. Rules for Medicare supplement benefit plans considered available for purchase versus discontinued plans.

1. Except as provided in Section 14.F.1.a., an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the Commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

- a. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the Commissioner in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the Commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.
  - b. An issuer that discontinues the availability of a policy form or certificate form pursuant to Section 14.F.1.a. shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the Commissioner of the discontinuance. The period of discontinuance may be reduced if the Commissioner determines that a shorter period is appropriate.
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 Section 14.F.1. unless the issuer complies with the following requirements:
  - a. The issuer provides an actuarial memorandum, in a form and manner prescribed by the Commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and 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. The Commissioner may approve a change to the differential which is in the public interest.

G. Each filing of premium rates will include applicable experience as outlined below.

1. Except as provided in Section 14.G.2., 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 13 of this regulation.
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.

H. Each filing of premium rates is expected to include the following items for each policy form included in the filing. Filings not containing these items may be returned to the filing company as incomplete.

1. The expected loss ratio by duration for the life of the policy form. These durational expected loss ratios will be evaluated for reasonableness.
2. Each rate filing shall compare the actual to the expected loss ratio by duration since inception of the policy form. This comparison should:
  - a. Be prepared on a calendar year basis including a row for each duration and a total row including the expected overall loss ratio for that calendar year; and

- b. Include a summary comparison over all durations, including the overall expected loss ratio over all durations.

This analysis is considered to be most important in the final decision to approve or disapprove a rate increase request.

- 3. Each rate filing shall demonstrate that the third year, and each subsequent year, loss ratio, for policies in force for three years or longer, is greater than or equal to the applicable percentage in Section 13.A.1.a. or 2., or provide acceptable justification as to why this requirement has not yet been met.
- 4. Each rate filing shall include all the actuarial memorandum requirements found in Colorado Insurance Regulation 4-2-11.

I. Each Medicare supplement rate filing submitted in Colorado, including annual rate filings, shall include the following Actuarial Certification on a separate page of the rate filing:

- 1. To the best of my knowledge and judgment, the following are true with respect to this Medicare supplement rate filing;
- 2. The assumptions present my 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;
- 3. The anticipated lifetime loss ratio, future loss ratios, and third year loss ratios all equal or exceed the applicable required loss ratio in Colorado;
- 4. The filed rates maintain the proper relationship between policies which were originally filed with differing rating methodologies;
- 5. The filing was prepared based on current standards of practice as promulgated by the Actuarial Standards Board, including the data quality standard of practice;
- 6. The filing is in compliance with applicable Colorado laws and regulations;
- 7. The rates are reasonable in relationship to benefits; and
- 8. A qualified actuary shall sign and date the certification. The actuary's professional credentials and company affiliation should be included below the signature.

J. The full credibility standard for Medicare supplement policies is 2000 life-years, and 2000 claims, for rating purposes. These standards must be met in a maximum of three (3) years. Any filing which bases its conclusions on data not meeting these standards is considered not fully credible unless the issuer can justify a lesser standard of full credibility. If the underlying data is not fully credible, for purposes of rate filings only, the filing should aggregate the underlying data according to the following requirements. Once the data has been aggregated, for purposes of rate filings, the data is expected to be aggregated in the same manner for all future rate filings unless further aggregation is necessary to achieve full credibility. Each rate filing must discuss how the data relied upon for the rate revision meets the Colorado data credibility requirement.

- 1. Pre-standardized Forms: If experience for the pre-standardized forms is not fully credible by form, the experience should be combined over all pre-standardized forms. If the combined experience is still not fully credible, the experience must be:
  - a. Combined with the experience for similar pre-standardized forms marketed by an affiliated company; or

- b. Combined with experience for the standardized forms.
- 2. Standardized Forms: If experience for a standardized form is not fully credible, experience should be either aggregated with the experience of the most similar standardized form(s) to achieve full credibility; or aggregated over all standardized forms. If the experience has been aggregated over all standardized forms to achieve the credibility standard, the indicated increase, following the aggregate analysis, may be allocated over the standardized forms in a manner to be determined by the issuer, providing that the sum of the proposed increases over all forms, is numerically equal to the indicated amount from the aggregate analysis. This allows the rate relationships over forms to remain reasonable. Rate changes for all affected standardized forms should be made concurrently.
- 3. Alternative Means: If full credibility cannot be achieved using the above methodology, a weighted average approach should be incorporated in determining a reasonable rate increase. The issuer should assign the maximum weight possible to the Colorado data and use an acceptable alternative data source to compliment this data.

K. The following items will be evaluated in determining the acceptability of a rate change request:

- 1. All of the required items from Colorado Insurance Regulation 4-2-11, in particular support for each of the underlying rating assumptions, such as the persistency and trend assumptions, used to calculate the earned premiums and incurred claims.
- 2. A discussion as to how the underlying data meets the Colorado credibility requirement. Please see Section 14.J. of this regulation. Any rate change request, which bases its conclusions on data that is not fully credible, must discuss how the rate change request was modified for less than fully credible data. If the data is aggregated to meet the credibility requirement, the aggregated data should be used to demonstrate that the requirements of Sections 14.K. 3., 4., and 5. have been met.
- 3. The presentation as to how the rates for each year of the projection period were determined. These rates must be calculated using expected loss ratios greater than or equal to the composite expected loss ratios by duration that were derived from the expected loss ratios included in the original rate filing for the block of business, unless the issuer provides acceptable justification and support as to why these ratios are inappropriate. A composite weighted average of loss ratios that are greater than or equal to the originally filed expected loss ratios may be used for aggregated blocks of business, with an explanation as to how the expected loss ratios were determined.
- 4. A demonstration that the historical loss ratio, the loss ratios for each year of the projection period and the lifetime loss ratio are greater than or equal to the minimum loss ratio requirements from Section 13.A. of this regulation must be included as part of the rate change request.
- 5. The actual-to-expected loss ratio analysis for each calendar year by issue year, required by Section 14.H. of this regulation, must be included as part of the rate change request. In order for the rate change request to be considered, the overall actual-to-expected loss ratio for the most recent full calendar year, and for the current partial calendar year if historical data is provided, must be greater than or equal to 1.0 or, in cases where this ratio is less than 1.0, an acceptable reason(s) as to why the rate change request should be considered must accompany the rate change request.

6. Rates for the category "under age 65" must be calculated using Section 10.E. of this regulation and the expected loss ratio as described in Section 14.K.5. must be used to calculate the "indicated premiums" for each plan.
- L. Rates and policy forms shall be submitted electronically in a form specified by the Division.

## **Section 15      Permitted Compensation Arrangements**

- A. An issuer or other entity may provide commission or other compensation to a 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 at least five (5) renewal years.
- C. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.
- 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 finders fees.

## **Section 16      Required Disclosure Provisions**

- A. General Rules
  1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision shall be consistent with the type of contract to be 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 or certificate holder's age.
  2. Except for riders or endorsements by which the issuer 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 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. A Medicare supplement policy or certificate 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. Such notice shall include in bold face type the address and telephone number of the Colorado Division of Insurance and a statement that in the event the issuer does not refund the premium within thirty (30) days from the date such refund is requested, the Division should be informed accordingly.
6. Guide to Health Insurance for People with Medicare
  - 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" ("Guide") in the form developed jointly by the National Association of Insurance Commissioners and Centers for Medicare and Medicaid Services and in a type size no smaller than twelve (12) point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment 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 the time the policy is delivered.
  - b. For the purposes of this section, "form" means the language, format, size, 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 policies or certificates in a format acceptable to the Commissioner. 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. Medicare Modernization Act (MMA) Notice Requirements

Issuers shall comply with any and all 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 acknowledgment of receipt of such outline from the applicant; and
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 such policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name.

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

3. The outline of coverage provided to applicants pursuant to this subsection consists of four (4) parts: 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 outline of coverage shall include all of the items contained in Appendix B.

E. Notice Regarding Policies or Certificates which are not Medicare Supplement Policies

1. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy or a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.); disability income policy; or other policy identified in Section 3.B. of this regulation, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insured under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language:

THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from [issuer]."

2. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Section 16.E.1. shall disclose, using the applicable statement in Appendix E, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

**Section 17 Requirements for Application Forms and Replacement Coverage**

A. Application forms shall include the following statements and questions designed to elicit information as to whether, as of the date of the application, the applicant currently has a Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace or be in addition to any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer containing such questions and statements may be used.

[Statements]

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid or may not need a Medicare supplement policy.
4. If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested during your entitlement to benefits under Medicaid for twenty four (24) months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

[Questions]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare

supplement plans. Please include a copy of the notice from your prior insurer with your application.  
PLEASE ANSWER ALL QUESTIONS.

[Please mark "Yes" or "No" below with an "X"]

(1) To the best of your knowledge,

(a) Did you turn age 65 in the last 6 months?

Yes  No

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes  No

If yes, what is the effective date? \_\_\_\_\_

(2) Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes  No

If yes,

(1) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes  No

(2) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes  No

(3) If you had coverage from any Medicare plan other than original Medicare within the past 6 months (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START \_\_\_\_ / \_\_\_\_ / \_\_\_\_ END \_\_\_\_ / \_\_\_\_ / \_\_\_\_

(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes  No

(b) Was this your first time in this type of Medicare plan?

Yes  No

(c) Did you drop a Medicare supplement policy to enroll in this Medicare plan?

Yes  No

(d) Has your coverage under the previous plan been involuntarily terminated for reasons other than nonpayment of premiums or for fraud?

Yes  No

(4) Do you have another Medicare supplement policy in force?

Yes  No

(a) If so, with what company, and what plan do you have [optional for Direct Mailers]?

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(b) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes  No

(5) Have you had coverage under any other health insurance within the past 6 months? (For example, an employer, union, or individual plan.)

Yes  No

(a) If so, with what company and what kind of policy?

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(b) What are your dates of coverage under the other policy?

START  /  /  END  /  /

(If you are still covered under the other policy, leave "END" blank.)

(c) Has your coverage under a previous policy been involuntarily terminated for reasons other than nonpayment of premiums or for fraud?

Yes  No

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

- D. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its producer, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of such notice signed by the applicant and producer, except where the coverage is sold without a producer, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.
- E. The Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage, in Appendix C, required by Section 17.D. for an issuer, shall be provided in the format prescribed and separately adopted by the Commissioner of Insurance, in no less than twelve (12) point type.
- F. Paragraphs 1. and 2., contained in such Notice to the Applicant Regarding Replacement of Medicare Supplement Insurance, (applicable to preexisting conditions), in Appendix C, may be deleted by an issuer if the replacement does not involve the application of a new preexisting condition limitation.

## **Section 18 Filing Requirements for Advertising**

- A. An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio, television, websites, other media or sales presentations, to the Commissioner for review. Such advertisement shall comply with all applicable requirements of Colorado Division of Insurance Regulation 4-2-3, and related guidelines as amended.
- B. Such advertisements shall also include a disclosure that all Medicare supplement standardized plans are offered to qualified individuals under the age of 65, or a disclosure that all Medicare supplement standardized plans are offered to Medicare qualified individuals due to disability and must be clearly visible in the advertisement or web page.
- C. This disclosure shall be presented in a clear, conspicuous and reasonably understandable manner, and designed to call attention to the nature and significance of the information it contains. The disclosure is considered designed to call attention to the nature and significance of the information in it if the issuer:
  1. Uses a typeface and type size that are easy to read;
  2. Provides wide margins and ample line spacing;
  3. Uses boldface, italics, underscoring, or capitals for key words and phrases; and
  4. In a form that combines the disclosure with other information, uses a plain-language heading to call attention to the disclosure portion of the document, and uses a type size that is greater than the type size predominantly used in the rest of the document.
- D. Advertising shall be submitted electronically in a format specified by the Division.

## **Section 19 Standards for Marketing**

- A. An issuer, directly or through its producers, shall:
  1. Establish marketing procedures to assure that any comparison of policies by its producers will be fair and accurate;

2. Establish marketing procedures to assure excessive insurance is not sold or issued;
3. Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

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

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 any such insurance; and
5. Establish auditable procedures for verifying compliance with this Section 19.A.

B. In addition to the practices prohibited in § 10-3-1104, C.R.S., the following acts and practices are prohibited:

1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or issuers 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 issuer.
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.
3. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

C. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is being marketed and issued in compliance with this regulation.

## **Section 20      Appropriateness of Recommended Purchase and Excessive Insurance**

- A. In recommending the purchase or replacement of any Medicare supplement policy or certificate, a producer shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.
- B. Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.
- C. An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Medicare Part C coverage.

## **Section 21      Reporting of Multiple Policies**

- A. On or before March 1 of each year, an issuer shall report to the Division, using the Reporting Medicare Supplement Policies Form prescribed and separately adopted by the Commissioner of Insurance (Appendix D), which provides the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate.

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

B. The items set forth above must be grouped by individual policyholder.

C. An issuer must only submit a report if there are consumers that have more than one Medicare Supplement policy or certificate.

**Section 22 Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates**

- A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent such period had elapsed under the original policy or certificate.
- B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

**Section 23 Readability Standards**

A Medicare supplement policy shall meet the following readability standards:

- A. The text must achieve a minimum score of 40 on the Flesch reading ease test;
- B. The policy shall be printed, except for specification pages, schedules and tables, in not less than ten (10) point type, one point leaded;
- C. The style, arrangement and overall appearance of the policy shall not give undue prominence to any portion of the text of the policy or to any endorsement or riders; and
- D. The policy shall contain a table of contents or an index of the principal sections of the policy if the policy has more than 3,000 words printed on three (3) or fewer pages of text or if the policy has more than three (3) pages regardless of the number of words.

**Section 24 Medicare Select Policies and Certificates**

- A. This section shall apply to Medicare Select policies and certificates, as defined in this section.
- B. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.
- C. 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.
7. "Service area" means the geographic area approved by the Commissioner within which an issuer is authorized to offer a Medicare Select policy.

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

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

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

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:
    - (1) To deliver adequately all services that are subject to a restricted network provision; or
    - (2) 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.
- 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 Subparagraph 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 Section 24.I.
7. Any other information requested by the Commissioner.

G. 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 Commissioner prior to implementing the changes. Changes shall be considered approved by the Commissioner after thirty (30) days unless specifically disapproved. An updated list of network providers shall be filed with the Commissioner at least quarterly.

H. 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.

I. 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.

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

K. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Section 24.J. and that the applicant understands the restrictions of the Medicare Select policy or certificate.

L. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the policyholders. 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 to the Commissioner, no later than March 31 of each year, regarding its grievance procedure. The report shall be in a format prescribed by the Commissioner and shall contain the number of grievances filed in the past calendar year and a summary of the subject, nature and resolution of such grievances.

M. 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.

N. 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.

- O. For the purposes of this section, 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 subsection, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Medicare Part B excess charges.
- P. 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 subparagraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Medicare Part B excess charges.
- Q. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies for the purpose of evaluating the Medicare Select Program.

## **Section 25      Incorporated Materials**

The "Flesch reading ease test and the National Association of Insurance Commissioners (NAIC) Life and Health Insurance Policy Language Simplification Act" shall mean the "Flesch reading ease test and the National Association of Insurance Commissioners (NAIC) Life and Health Insurance Policy Language Simplification Act" as published on the effective date of this regulation and does not include later amendments to or editions of the "Flesch reading ease test and the National Association of Insurance Commissioners (NAIC) Life and Health Insurance Policy Language Simplification Act". A copy of the "Flesch reading ease test and the National Association of Insurance Commissioners (NAIC) Life and Health Insurance Policy Language Simplification Act" may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of the "Flesch reading ease test and the National Association of Insurance Commissioners (NAIC) Life and Health Insurance Policy Language Simplification Act" may be requested from the Colorado Division of Insurance for a fee. A charge for certification or copies may apply.

## **Section 26      Severability**

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

## **Section 27      Enforcement**

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocations of license, subject to the requirements of due process.

## **Section 28      Effective Date**

This emergency regulation shall be effective November 19, 2020.

**Section 29 History**

New Regulation 81-1 effective January 1, 1982.  
Regulation 81-1 repealed and replaced by 89-7.  
Regulation 89-7 repealed and replaced by 90-4, effective January 1, 1991.  
Regulation 90-4 repealed and replaced by 91-18.  
Regulation 91-18 repealed and replaced by 4-3-1 effective May 1, 1992.  
Regulation 4-3-1 was amended effective April 1, 1996.  
Regulation 4-3-1 was amended effective September 1, 1996.  
Regulation 4-3-1 was amended effective April 1, 1999  
Regulation 4-3-1 was amended effective January 1, 2001.  
Regulation 4-3-1 was amended effective September 1, 2003.  
Sections 10(E)(2), 27 and 28 were amended effective December 1, 2003  
Regulation 4-3-1 was amended effective February 1, 2005.  
Regulation 4-3-1 was amended effective December 1, 2005.  
Regulation 4-3-1 was amended effective February 1, 2006.  
Emergency regulation 08-E-8 is effective January 1, 2009.  
Regulation 4-3-1 was amended effective February 1, 2009.  
Regulation 4-3-1 was amended effective June 1, 2009.  
Regulation 4-3-1 was amended effective January 1, 2010.  
Regulation 4-3-1 was amended effective December 1, 2018.  
Emergency regulation 20-E-14 is effective November 19, 2020.

**APPENDIX A**

**MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR**  
**CALENDAR YEAR\_\_\_\_\_**

TYPE <sup>1</sup>	SMSBP <sup>2</sup>
For the State of:	Company Name:
NAIC Group Code:	NAIC Company Code:
Address:	Person Completing Exhibit:
Title:	Telephone Number:

Line		(a) Earned Premium <sup>3</sup>	(b) Incurred Claims <sup>4</sup>
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues <sup>5</sup>		
	c. Net (for reporting purposes = 1a-1b)		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		
4.	Refunds Last Year (Excluding Interest)		
5.	Previous Since Inception (Excluding Interest)		
6.	Refunds Since Inception (Excluding Interest)		
7.	Benchmark Ratio Since Inception (see worksheet for Ratio 1)		
8.	Experienced Ratio Since Inception (Ratio 2) Total Actual Incurred Claims (line 3, col. b) Total Earned Prem. (line 3, col. a)–Refunds Since Inception (line 6)		
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life year's exposure, then proceed to calculation of refund.		
10.	Tolerance Permitted (obtained from credibility table)		
11.	Adjustment to Incurred Claims for Credibility		
	Ratio 3 = Ratio 2 + Tolerance		

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.

If Ratio 3 is less than the Benchmark Ratio, then proceed.

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

3 Includes Modal Loadings and Fees Charged

4 Excludes Active Life Reserves

5 This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

APPENDIX A (continued)

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR  
CALENDAR YEAR \_\_\_\_\_

TYPE <sup>1</sup>	SMSBP <sup>2</sup>
For the State of:	Company Name:
NAIC Group Code:	NAIC Company Code:
Address:	Person Completing Exhibit:
Title:	Telephone Number:

Medicare Supplement Credibility Table

Life Years Exposed		
Since Inception		Tolerance
10,000+		0.0%
5,000 -9,999		5.0%
2,500 -4,999		7.5%
1,000 -2,499		10.0%
500 - 999		15.0%
If less than 500, no credibility.		

12.	Adjusted Incurred Claims [Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6)] x Ratio 3 (line 11)	
13.	Refund = Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6) – [Adjusted Incurred Claims (line 12) / Benchmark Ratio (Ratio 1)]	

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name - Please Type

\_\_\_\_\_  
Title - Please Type

\_\_\_\_\_  
Date



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

FOR CALENDAR YEAR \_\_\_\_\_

TYPE<sup>1</sup>

For the State of:

SMSBP<sup>2</sup>

NAIC Group Code:

Company Name:

Address:

NAIC Company Code:

Title:

Person Completing Exhibit:

Telephone Number:

(a) <sup>3</sup>	(b) <sup>4</sup>	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) <sup>5</sup>
Year	Earned Premium	Factor	(b) x (c)	Cumulative Loss Ratio	(d) x (e)	Factor	(b) x (g)	Cumulative Loss Ratio	(h) x (i)	Policy Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

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

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans

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

4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

6 To include the earned premium for all years prior to as well as the 15<sup>th</sup> year prior to the current year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES  
FOR CALENDAR YEAR \_\_\_\_\_

TYPE<sup>1</sup>

For the State of:

NAIC Group Code:

Address:

Title:

SMSBP<sup>2</sup>

Company Name:

NAIC Company Code:

Person Completing Exhibit:

Telephone Number:

(a) <sup>3</sup>	(b) <sup>4</sup>	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) <sup>5</sup>
Year	Earned Premium	Factor	(b) x (c)	Cumulative Loss Ratio	(d) x (e)	Factor	(b) x (g)	Cumulative Loss Ratio	(h) x (i)	Policy Loss Ratio
1	2.770			0.442		0.000		0.000		0.40
2	4.175			0.493		0.000		0.000		0.55
3	4.175			0.493		1.194		0.659		0.65
4	4.175			0.493		2.245		0.669		0.67
5	4.175			0.493		3.170		0.678		0.69
6	4.175			0.493		3.998		0.686		0.71
7	4.175			0.493		4.754		0.695		0.73
8	4.175			0.493		5.445		0.702		0.75
9	4.175			0.493		6.075		0.708		0.76
10	4.175			0.493		6.650		0.713		0.76
11	4.175			0.493		7.176		0.717		0.76
12	4.175			0.493		7.655		0.720		0.77
13	4.175			0.493		8.093		0.723		0.77
14	4.175			0.493		8.493		0.725		0.77
15+	4.175			0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

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

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans

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

4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

6 To include the earned premium for all years prior to as well as the 15<sup>th</sup> year prior to the current year.

## APPENDIX B

### Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every issuer must make Plan "A" available. Some plans may not be available in your state. Plans E, H, I, and J are no longer available for sale.

In Colorado, it is a requirement that all plans offered by [Issuer] are available to under age 65 Medicare qualified individuals.

#### Basic Benefits:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance				
	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible					
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)	Part B Excess (100%)					
		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency				
* Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2,240] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$2,240]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.							Out-of-pocket limit \$[5,240]; paid at 100% after limit reached	Out-of-pocket limit \$[2,620]; paid at 100% after limit reached		

## APPENDIX B

### 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.

In Colorado, it is a requirement that all plans offered by [Issuer] are available to under age 65 Medicare qualified individuals.

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 <sup>1</sup>	K	L	M	N	C	F <sup>1</sup>
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 <sup>3</sup>	✓	✓
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 [2018]				[\$5,240] <sup>2</sup>	[\$2,620] <sup>2</sup>					

<sup>1</sup> Plans F and G also have a high deductible option which require first paying a plan deductible of [\$2,240] 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.

<sup>2</sup> 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.

<sup>3</sup> 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.

## **READ YOUR POLICY VERY CAREFULLY [Boldface Type]**

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

## **RIGHT TO RETURN POLICY [Boldface Type]**

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

## **POLICY REPLACEMENT [Boldface Type]**

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

## **NOTICE [Boldface Type]**

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

[For agents:]

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

[For direct response:]

[Insert issuer'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 Section 9.1.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 Commissioner.]

## PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>  Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but \$[1,340]	\$0	\$[1,340](Part A deductible)
• 61st thru 90th day	All but \$[335] a day	\$[335] a day	\$0
• 91st day and after: While using 60 lifetime reserve days	All but \$[670] a day	\$[670] a day	\$0
Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
• Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>  You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
• First 20 days	All approved amounts	\$0	\$0
• 21 <sup>st</sup> thru 100th day	All but \$[167.50] a day	\$0	Up to \$[167.50] a day
• 101st day and after	\$0	\$0	All costs
<b>BLOOD</b> • First 3 pints • Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0
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**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN A

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

\* Once you have been billed \$[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
<ul style="list-style-type: none"> <li>• First \$[183] of Medicare-Approved Amounts*</li> </ul>	\$0	\$0	\$[183] (Part B deductible)
<ul style="list-style-type: none"> <li>• Remainder of Medicare-Approved Amounts</li> </ul>	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
<ul style="list-style-type: none"> <li>• First 3 pints</li> </ul>	\$0	All costs	\$0
<ul style="list-style-type: none"> <li>• Next \$[183] of Medicare-Approved Amounts*</li> </ul>	\$0	\$0	\$[183] (Part B deductible)
<ul style="list-style-type: none"> <li>• Remainder of Medicare-Approved Amounts</li> </ul>	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN A****PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE</b> <b>MEDICARE-APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment <ul style="list-style-type: none"><li>First \$[183] of Medicare-Approved Amounts*</li></ul>	\$0	\$0	\$[183] (Part B deductible)
<ul style="list-style-type: none"><li>Remainder of Medicare-Approved Amounts</li></ul>	80%	20%	\$0

## PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but \$[1,340]	\$[1,340](Part A deductible)	\$0
• 61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$[335] a day	\$[335] a day	\$0
• 91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$[670] a day	\$[670] a day	\$0
Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
• Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	\$0	\$0
• 21 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$[167.50] a day	0	Up to \$[167.50] a day
• 101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b> • First 3 pints	\$0	3 pints	\$0
• Additional amounts	100%	\$0	\$0

<b>HOSPICE CARE</b>  You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0
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**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN B

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

\* Once you have been billed \$[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
• First \$[183] of Medicare-Approved Amounts*	\$0	\$0	\$[183] (Part B deductible)
• Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> • First 3 pints	\$0	All costs	\$0
• Next \$[183] of Medicare-Approved Amounts*	\$0	\$0	\$[183] (Part B deductible)
• Remainder of Medicare-Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN B****PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
• First \$[183] of Medicare-Approved Amounts*	\$0	\$0	\$[183] (Part B deductible)
• Remainder of Medicare-Approved Amounts	80%	20%	\$0

## PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>  Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but \$[1,340]	\$[1,340](Part A deductible)	\$0
• 61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$[335] a day	\$[335] a day	\$0
• 91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$[670] a day	\$[670] a day	\$0
Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
• Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>  You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	\$0	\$0
• 21 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$[167.50] a day	Up to \$[167.50] a day	\$0
• 101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			
• First 3 pints	\$0	3 pints	\$0
• Additional amounts	100%	\$0	\$0

<b>HOSPICE CARE</b>  You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0
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**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN C

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

\*Once you have been billed \$[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
• First \$[183] of Medicare-Approved Amounts*	\$0	\$[183] (Part B deductible)	\$0
• Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
• First 3 pints	\$0	All costs	\$0
• Next \$[183] of Medicare-Approved Amounts*	\$0	\$[183] (Part B deductible)	\$0
• Remainder of Medicare-Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

### PLAN C

<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment <ul style="list-style-type: none"> <li>• First \$[183] of Medicare-Approved Amounts*</li> </ul>	\$0	\$[183](Part B deductible)	\$0
• Remainder of Medicare-Approved Amounts	80%	20%	\$0

### PLAN C

#### OTHER BENEFITS—NOT COVERED BY MEDICARE

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

## PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>  Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but \$[1,340]	\$[1,340] (Part A deductible)	\$0
• 61st thru 90th day	All but \$[335] a day	\$[335] a day	\$0
• 91st day and after: While using 60 lifetime reserve days	All but \$[670] a day	\$[670] a day \$0	\$0
Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0
• Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>  You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	\$0	\$0
• 21 <sup>st</sup> thru 100th day	All but \$[167.50] a day	Up to \$[167.50] a day	\$0
• 101st day and after	\$0	\$0	All costs
<b>BLOOD</b> • First 3 pints • Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0
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**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN D

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

\* Once you have been billed \$[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
• First \$[183] of Medicare-Approved Amounts*	\$0	\$0	\$[183] (Part B deductible)
• Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> • First 3 pints	\$0	All costs	\$0
• Next \$[183] of Medicare-Approved Amounts*	\$0	\$0	\$[183] (Part B deductible)
• Remainder of Medicare-Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN D****PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$[183] of Medicare-Approved Amounts*	\$0	\$0	\$[183] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

**PLAN D****OTHER BENEFITS—NOT COVERED BY MEDICARE**

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

## PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

**[\*\*This high deductible plan pays the same benefits as Plan F after you have paid a calendar year [\$2,240] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$2,240]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY [\$2,240] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO [\$2,240] DEDUCTIBLE, **] YOU PAY
<b>HOSPITALIZATION*</b>  Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but \$[1,340]	\$[1,340] (Part A deductible)	\$0
• 61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$[335] a day	\$[335] a day	\$0
• 91 <sup>st</sup> day and after: While using 60 Lifetime reserve days	All but \$[670] a day	\$[670] a day	\$0
Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0***
• Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>  You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	\$0	\$0

• 21 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$[167.50] a day	Up to \$[167.50] a day	\$0
• 101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			
• First 3 pints • Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

## PLAN F or HIGH DEDUCTIBLE PLAN F

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

\*Once you have been billed \$[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**[\*\*This high deductible plan pays the same benefits as Plan F after you have paid a calendar year [\$2,240] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$2,240]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[\$2,240] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO \$[\$2,240] DEDUCTIBLE, **] YOU PAY
<b>MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
<ul style="list-style-type: none"> <li>First \$[183] of Medicare-Approved Amounts*</li> </ul>	\$0	\$[183] (Part B deductible)	\$0
<ul style="list-style-type: none"> <li>Remainder of Medicare-Approved Amounts</li> </ul>	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b>			
<ul style="list-style-type: none"> <li>First 3 pints</li> </ul>	\$0	All costs	\$0
<ul style="list-style-type: none"> <li>Next \$[183] of Medicare- Approved Amounts*</li> </ul>	\$0	\$[183] (Part B deductible)	\$0
<ul style="list-style-type: none"> <li>Remainder of Medicare- Approved Amounts</li> </ul>	80%	20%	\$0

<b>CLINICAL LABORATORY SERVICES—</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
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## PLAN F or HIGH DEDUCTIBLE PLAN F

### PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2,240] DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO \$[2,240] DEDUCTIBLE, ** YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
• First \$[183] of Medicare- approved Amounts*	\$0	\$[183] (Part B deductible)	\$0
• Remainder of Medicare- Approved Amounts	80%	20%	\$0

### PLAN F

#### OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2,240] DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO \$[2,240] DEDUCTIBLE, ** YOU PAY
<b>FOREIGN TRAVEL-- NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
• First \$250 each calendar year	\$0	\$0	\$250
• Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

## PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but \$[1,340]	\$[1,340] (Part A deductible)	\$0
• 61st thru 90th day	All but \$[335] a day	\$[335] a day	\$0
• 91st day and after: While using 60 lifetime reserve days	All but \$[670] a day	\$[670] a day	\$0
Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
• Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	\$0	\$0
• 21 <sup>st</sup> thru 100th day	All but \$[167.50] a day	Up to \$[167.50] a day	\$0
• 101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
• First 3 pints	\$0	3 pints	\$0
• Additional amounts	100%	\$0	\$0

<b>HOSPICE CARE</b>  You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0
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**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN G

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

\*Once you have been billed \$[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
• First \$[183] of Medicare-Approved Amounts*	\$0	\$0	\$[183] (Part B deductible)
• Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> • First 3 pints	\$0	All costs	\$0
• Next \$[183] of Medicare-Approved Amounts*	\$0	\$0	\$[183] (Part B deductible)
• Remainder of Medicare-Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

## PLAN G

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$[183] of Medicare-Approved Amounts*	\$0	\$0	\$[183] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

## PLAN G

### OTHER BENEFITS—NOT COVERED BY MEDICARE

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

**PLAN G OR HIGH DEDUCTIBLE PLAN G EFFECTIVE JANUARY 1, 2020****MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

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

[\*\*This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [\$2,240] deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are [\$2,240]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY \$[2,240] DEDUCTIBLE, **] PLAN PAYS</b>	<b>[IN ADDITION TO \$[2,240] DEDUCTIBLE, **] YOU PAY</b>
<b>HOSPITALIZATION*</b>  Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but \$[1,340]	\$[1,340] (Part A deductible)	\$0
• 61st thru 90th day	All but \$[335] a day	\$[335] a day	\$0
• 91st day and after: While using 60 lifetime reserve days	All but \$[670] a day	\$[670] a day	\$0
Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0***
• Beyond the additional 365 days	\$0	\$0	All costs

<b>SKILLED NURSING FACILITY CARE*</b>  You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	\$0	\$0
• 21 <sup>st</sup> thru 100th day	All but \$[167.50] a day	Up to \$[167.50] a day	\$0
• 101st day and after	\$0	\$0	All costs
<b>BLOOD</b>  • First 3 pints	\$0	3 pints	\$0
• Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>  You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

**PLAN G OR HIGH DEDUCTIBLE PLAN G EFFECTIVE JANUARY 1, 2020**

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

\*Once you have been billed \$[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[\*\*This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [\$2,240] deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are [\$2,240]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY \$[2,240] DEDUCTIBLE,**] PLAN PAYS</b>	<b>[IN ADDITION TO \$[2,240] DEDUCTIBLE,**] YOU PAY</b>
<b>MEDICAL EXPENSES-- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
• First \$[183] of Medicare- Approved Amounts*	\$0	\$0	\$[183] (Unless Part B deductible has been met)
• Remainder of Medicare- Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> • First 3 pints	\$0	All costs	\$0
• Next \$[183] of Medicare- Approved Amounts*	\$0	\$0	\$[183] (Unless Part B deductible has been met)
• Remainder of Medicare- Approved Amounts	80%	20%	\$0

<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0
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**PLAN G OR HIGH DEDUCTIBLE PLAN G EFFECTIVE JANUARY 1, 2020**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY \$[2,240] DEDUCTIBLE,]** PLAN PAYS</b>	<b>[IN ADDITION TO \$[2,240] DEDUCTIBLE,]** YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$[183] of Medicare-Approved Amounts*	\$0	\$0	\$[183] (Unless Part B deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

**PLAN G or HIGH DEDUCTIBLE PLAN G OTHER**

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY \$[2,240] DEDUCTIBLE,]** PLAN PAYS</b>	<b>[IN ADDITION TO \$[2,240] DEDUCTIBLE,]** YOU PAY</b>
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b>  Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
• First \$250 each calendar year	\$0	\$0	\$250

• Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
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## PLAN K

\* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[5,240] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOSPITALIZATION**</b>  Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but \$[1,340]	\$[670](50% of Part A deductible)	\$[670](50% of Part A deductible) ♦
• 61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$[335] a day	\$[335] a day	\$0
• 91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$[670] a day	\$[670] a day	\$0
Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0***
• Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE**</b>  You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	\$0	\$0
• 21 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$[167.50] a day	Up to \$[83.75] a day	Up to \$[83.75] a day ♦
• 101 <sup>st</sup> day and after	\$0	\$0	All costs

<b>BLOOD</b> <ul style="list-style-type: none"> <li>• First 3 pints</li> <li>• Additional amounts</li> </ul>	0 100%	50% \$0	50%♦ \$0
<b>HOSPICE CARE</b>  You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance♦

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

## PLAN K

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

\*\*\*\* Once you have been billed \$[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>MEDICAL EXPENSES-- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
• First \$[183] of Medicare-Approved Amounts****	\$0	\$0	\$[183] (Part B deductible)**** ♦
• Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare- approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
• Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$5,240])*
<b>BLOOD</b>			
• First 3 pints	\$0	50%	50% ♦
• Next \$[183] of Medicare- Approved Amounts****	\$0	\$0	\$[183] (Part B deductible)**** ♦
• Remainder of Medicare- Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[5,240] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this

difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**PLAN K****PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY*</b>
<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
• First \$[183] of Medicare-Approved Amounts*****	\$0	\$0	\$[183] (Part B deductible) ♦
• Remainder of Medicare-Approved Amounts	80%	10%	10% ♦

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

## PLAN L

\* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[2,620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOSPITALIZATION**</b>  Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but \$[1,340]	\$[1,005] (75% of Part A deductible)	\$[335] (25% of Part A deductible) ♦
• 61st thru 90th day	All but \$[335] a day	\$[335] a day	\$0
• 91st day and after: While using 60 lifetime reserve days	All but \$[670] a day	\$[670] a day	\$0
Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0***
• Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE**</b>  You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	\$0	\$0
• 21 <sup>st</sup> thru 100th day	All but \$[167.50] a day	Up to \$[125.63] a day	Up to \$[41.88] a day ♦
• 101st day and after	\$0	\$0	All costs

<b>BLOOD</b> <ul style="list-style-type: none"><li>• First 3 pints</li><li>• Additional amounts</li></ul>	\$0 100%	75% \$0	25%♦ \$0
<b>HOSPICE CARE</b>  You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance	25% of copayment/coinsurance♦

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

## PLAN L

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

\* Once you have been billed (\$183) of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>MEDICARE EXPENSES— IN OR OUT OF THE HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$[183] of Medicare- Approved Amounts****	\$0	\$0	\$[183] (Part B deductible)****♦
Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare- approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare- Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
<b>Part B Excess Charges</b> (Above Medicare- Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$2,620])*
<b>BLOOD</b>			
• First 3 pints	\$0	75%	25%♦
• Next \$[183] of Medicare-Approved Amounts****	\$0	\$0	\$[183] (Part B deductible)♦
• Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2,620] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this

difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**PLAN L****PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY*</b>
<b>HOME HEALTH CARE</b> MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment <ul style="list-style-type: none"><li>• First \$[183] of Medicare-Approved Amounts*****</li></ul>	\$0	\$0	\$[183] (Part B deductible) ♦
• Remainder of Medicare-Approved Amounts	80%	15%	5% ♦

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

## PLAN M

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>  Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but \$[1,340]	\$670](50% of Part A deductible)	\$[670](50% of Part A deductible)
• 61 <sup>st</sup> thru 90th day	All but \$[335] a day	\$[335] a day	\$0
• 91 <sup>st</sup> day and after: • While using 60 lifetime reserve days	All but \$[670] a day	\$[670] a day	\$0
Once lifetime reserve days are used: • Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
• Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>  You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	\$0	\$0
• 21 <sup>st</sup> thru 100th day	All but \$[167.50] a day	Up to \$[167.50] a day	\$0
• 101st day and after	\$0	\$0	All costs
<b>BLOOD</b> • First 3 pints • Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0
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**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional three hundred and sixty five (365) days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN M

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

\* Once you have been billed \$[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment</b>			
<ul style="list-style-type: none"> <li>• First \$[183] of Medicare-Approved Amounts*</li> </ul>	\$0	\$0	\$[183] (Part B deductible)
<ul style="list-style-type: none"> <li>• Remainder of Medicare-Approved Amounts</li> </ul>	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges (Above Medicare- Approved Amounts)</b>	\$0	\$0	All costs
<b>BLOOD</b>			
<ul style="list-style-type: none"> <li>• First 3 pints</li> </ul>	\$0	All costs	\$0
<ul style="list-style-type: none"> <li>• Next \$[183] of Medicare-Approved Amounts*</li> </ul>	\$0	\$0	\$[183] (Part B deductible)
<ul style="list-style-type: none"> <li>• Remainder of Medicare-Approved Amounts</li> </ul>	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN M****PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY*</b>
<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$[183] of Medicare-Approved Amounts*	\$0	\$0	\$[183] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

**PLAN M****OTHER BENEFITS—NOT COVERED BY MEDICARE**

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

## PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but \$[1,340]	\$[1,340](Part A deductible)	\$0
• 61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$[335] a day	\$[335] a day	\$0
• 91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$[670] a day	\$[670] a day	\$0
Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
• Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	\$0	\$0
• 21 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$[167.50] a day	Up to \$[167.50] a day	\$0
• 101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b> • First 3 pints	\$0	3 pints	\$0
• Additional amounts	100%	\$0	\$0

<b>HOSPICE CARE</b>  You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0
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**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN N

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

\* Once you have been billed \$[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
<ul style="list-style-type: none"> <li>• First \$[183] of Medicare-Approved Amounts*</li> </ul>	\$0	\$0	\$[183] (Part B deductible)
<ul style="list-style-type: none"> <li>• Remainder of Medicare-Approved Amounts</li> </ul>	Generally 80%	Balance, other than up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
<ul style="list-style-type: none"> <li>• First 3 pints</li> </ul>	\$0	All costs	\$0
<ul style="list-style-type: none"> <li>• Next \$[183] of Medicare- Approved Amounts*</li> </ul>	\$0	\$0	\$[183] (Part B deductible)
<ul style="list-style-type: none"> <li>• Remainder of Medicare- Approved Amounts</li> </ul>	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN N****PARTS A & B**

<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$[183] of Medicare-Approved Amounts*	\$0	\$0	\$[183] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

**PLAN N****OTHER BENEFITS—NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL— NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
<ul style="list-style-type: none"> <li>First \$250 each calendar year</li> </ul>	\$0	\$0	\$250
<ul style="list-style-type: none"> <li>Remainder of Charges</li> </ul>	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

## APPENDIX C

### NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

[Issuer'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 terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Issuer Name]. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

#### STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [Optional only for Direct Mailers.]

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Other. (please specify) \_\_\_\_\_

1. Note: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. 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 still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the issuer 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, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

---

(Signature of Agent, Broker or Other Representative)\*

[Typed Name and Address of issuer, Agent or Broker]

---

(Applicant's Signature)

---

(Date)

\*Signature not required for direct response sales.

**APPENDIX D****FORM FOR REPORTING  
MEDICARE SUPPLEMENT POLICIES**

Issuer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate Number	Date of Issuance

\_\_\_\_\_  
Signature\_\_\_\_\_  
Name and Title (please type)\_\_\_\_\_  
Date

## APPENDIX E

### DISCLOSURE STATEMENTS

#### Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882(d) of the federal Social Security Act [42 U.S.C. Section 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits issuers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix E remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

## **IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

### **This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

#### **This insurance duplicates Medicare benefits when it pays:**

- Hospital or medical expenses up to the maximum stated in the policy

#### **Medicare generally pays for most or all of these expenses.**

#### **Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

### **Before You Buy This Insurance**

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Original disclosure statement for policies that provide benefits for specified limited services.]

## **IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

### **This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

#### **This insurance duplicates Medicare benefits when:**

- Any of the services covered by the policy are also covered by Medicare

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

### **Before You Buy This Insurance**

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

## **IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

### **This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

#### **This insurance duplicates Medicare benefits when it pays:**

- Hospital or medical expenses up to the maximum stated in the policy

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

### **Before You Buy This Insurance**

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

## **IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

### **This is not Medicare Supplement Insurance**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

### **Before You Buy This Insurance**

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

## **IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

### **This is not Medicare Supplement Insurance**

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

#### **This insurance duplicates Medicare benefits when:**

- Any expenses or services covered by the policy are also covered by Medicare

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

### **Before You Buy This Insurance**

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

## **IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

### **This is not Medicare Supplement Insurance**

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

#### **This insurance duplicates Medicare benefits when:**

- Any expenses or services covered by the policy are also covered by Medicare; or
- It pays the fixed dollar amount stated in the policy and Medicare covers the same event

#### **Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice care
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

### **Before You Buy This Insurance**

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

## **IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

### **This is not Medicare Supplement Insurance**

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

#### **This insurance duplicates Medicare benefits when it pays:**

- The benefits stated in the policy and coverage for the same event is provided by Medicare

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

### **Before You Buy This Insurance**

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

## **IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

### **Before You Buy This Insurance**

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT  
MEDICARE SUPPLEMENT INSURANCE**

**THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.**

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

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## **IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

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This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
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**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice
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## **IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice care
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

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