ORDER R 92-03 ADOPTING, AMENDING, OR REPEALING
REGULATIONS OF THE DIVISION OF INSURANCE

The attached 123 pages of regulations, including the technical edits by the Department of Law, dealing with disability insurance marketed as medicare supplements to comply with the requirements of 42 U.S.C. 1395ss so that the state may retain full authority to set certain standards for medicare supplemental insurance, are hereby adopted and certified to be correct copies of the regulations that the Division of Insurance amends, adopts, or repeals (3 AAC 28.220 and 3 AAC 28.410 -- 3 AAC 28.510) under the authority of AS 21.06.090 and after compliance with the Administrative Procedure Act (AS 44.62), specifically including notice under AS 44.62.190 and 44.62.200 and opportunity for public comment under AS 44.62.210.

This action is not expected to require an increased appropriation.

This order takes effect on the 1st day of July, 1992, as provided in AS 44.62.180.

DATED this 27th day of May, 1992, at Juneau, Alaska.

David J. Walsh, Director
Division of Insurance
Department of Commerce and
Economic Development

FILING CERTIFICATION

I, John B. Coghill, Lieutenant Governor for the State of Alaska, certify that on June 1, 1992 at 11:23 A.m., I filed the attached regulations according to the provisions of AS 44.62.040 -- 44.62.120.

Lieutenant Governor

Effective July 1, 1992.

Register 122, July 1992.

MEDSUPOR.RBK

TITLE 3. COMMERCE AND ECONOMIC DEVELOPMENT

CHAPTER 28. LIFE, DISABILITY, VARIABLE AND RELATED INSURANCE

Article 3 Filing of Rates

Section

220. Rate Filings When Required

3 AAC 28.220 is amended to read:

3 AAC 28.220. RATE FILINGS WHEN REQUIRED. Rate filings **for life and disability insurance** are not required [AND SHALL NOT BE MADE] unless the coverages involved are credit life, credit disability, **a medicare supplement policy**, or a filing by a hospital or medical service corporation. (Eff. 11/8/73, Register 48; am __/__/__, Register __)

Authority: AS 21.06.090

AS 21.57.090(a)

AS 21.87.190(b)

AS 21.89.060

Article 5 Disability Insurance Marketed as Medicare Supplements

Section

410.	Purpose
420.	Applicability and Scope
430.	Policy Definitions and Terms
440.	Policy Provisions
450.	Medicare Supplement Minimum Standards for Policies Issued Prior to the Effective Date of 3 AAC 28.453
451.	Termination by Group Policyholder; Conversion
452.	Compliance With 42 U.S.C. 1395ss (Omnibus Budget Reconciliation Act of 1990)
453.	Minimum Benefit Standards for Policies or Certificates Issued in this State on or after the Effective Date of this Section
455.	Standard Medicare Supplement Benefit Plans
456.	Medicare Select Policies and Certificates
457.	Open Enrollment
458.	Standards for Claims Payment
460.	Loss Ratio Standards and Refund or Credit of Premium
470.	Filings
471.	(Repealed)
472.	Filing and Approval of Policies, Certificates, and Premium Rates
490.	Required Disclosure Provisions
491.	(Repealed)
500.	Requirements for Application Forms and Replacement Coverage
501.	Permitted Compensation Arrangements
502.	Notice regarding policies or certificates that are not medicare supplement policies
503.	Filing Requirements for Advertising
504.	Standards for Marketing
505.	Appropriateness of Recommended Purchase and Excessive Insurance
506.	Reporting of Multiple Policies
507.	Prohibition Against Pre-existing Conditions, Waiting Periods, Elimination Periods, and Probationary Periods in Replacement Policies or Certificates
510.	Definitions

3 AAC 28.410 is amended to read:

3 AAC 28.410. PURPOSE. The purpose of 3 AAC 28.410 -- 3 AAC 28.510 is to protect the public by

(1) standardizing and simplifying the terms and benefits of medicare supplement policies [AND MEDICARE SUPPLEMENT SUBSCRIBER CONTRACTS];

(2) eliminating policy or **certificate** [CONTRACT] provisions which are misleading or confusing; [AND]

(3) providing for full disclosure **in the sale** [BY PERSONS TRANSACTING THE BUSINESS] of disability insurance **coverage** [OR DISABILITY SUBSCRIBER CONTRACTS] to persons eligible for medicare [BY REASON OF AGE]; **and**

(4) facilitating public understanding and comparison of medicare supplement policies [AND SUBSCRIBER CONTRACTS]. (Eff. 3/26/82, Register 81; am 8/8/90, Register 115; am __/__/__, Register __)

Authority: AS 21.06.090 AS 21.87.020
AS 21.36.020 AS 21.87.120

AS 21.36.030 AS 21.87.130
AS 21.36.040 AS 21.87.140
AS 21.36.050 AS 21.87.150
AS 21.42.090 AS 21.87.160
AS 21.42.120 AS 21.87.170
AS 21.42.130 AS 21.87.180
AS 21.86.220 AS 21.89.060

3 AAC 28.420 is amended to read:

3 AAC 28.420. APPLICABILITY AND SCOPE. Except as otherwise provided **in 3 AAC 28.450, 3 AAC 28.458, 3 AAC 28.460, 3 AAC 28.470, and 3 AAC 28.506**, 3 AAC 28.410-3 AAC 28.510 apply to all medicare supplement policies [AND SUBSCRIBER CONTRACTS] delivered or issued for delivery in this state **on or after the effective date of this regulation**. (Eff. 3/26/82, Register 81; am 8/8/90, Register 115; am __/__/__, Register __)

Authority: AS 21.06.090
AS 21.42.130
AS 21.89.060

3 AAC 28.430 is amended to read:

3 AAC 28.430. POLICY DEFINITIONS AND TERMS. [(a)] A medicare supplement policy **using the following terms or their equivalent** [OR MEDICARE SUPPLEMENT SUBSCRIBER CONTRACT WHICH USES THE FOLLOWING TERMS] must [DEFINE THEM] **contain terms and definitions** as follows:

(1) "accident," "accidental injury," or "accidental means" must use "result" language and may not include words which establish an accidental-means test or use words characterizing the accident or injury as "external, violent, or visible wounds" **or similar words of description or characterization**;

(2) "benefit period" or "medicare benefit period" may not be more restrictively defined than in the medicare program;

(3) "convalescent nursing home," "extended care facility," or "skilled nursing facility" **may not be more restrictively defined than in the medicare program** [MUST BE DEFINED TO INCLUDE ANY FACILITY WHICH

(A) IS OPERATED LAWFULLY;

(B) IS APPROVED FOR PAYMENT OF MEDICARE BENEFITS, OR IS QUALIFIED TO RECEIVE THAT APPROVAL IF REQUESTED;

(C) IS PRIMARILY ENGAGED IN PROVIDING, IN ADDITION TO ROOM AND BOARD ACCOMMODATION, SKILLED NURSING CARE UNDER THE SUPERVISION OF A LICENSED PHYSICIAN;

(D) PROVIDES CONTINUOUS 24-HOURS-A-DAY NURSING SERVICE BY OR UNDER THE SUPERVISION OF A REGISTERED GRADUATE OR PROFESSIONAL NURSE (R.N.); AND

(E) MAINTAINS A DAILY MEDICAL RECORD OF EACH PATIENT;]

[(4) "CONVALESCENT NURSING HOME," "EXTENDED CARE FACILITY," AND "SKILLED NURSING FACILITY" MAY NOT INCLUDE

(A) ANY HOME, FACILITY, OR PART OF ONE USED PRIMARILY FOR REST;

(B) A HOME OR FACILITY FOR THE AGED OR FOR THE CARE OF DRUG ADDICTS OR ALCOHOLICS; OR

(C) A HOME OR FACILITY PRIMARILY USED FOR THE CARE AND TREATMENT OF MENTAL DISEASES OR DISORDERS, OR CUSTODIAL OR EDUCATIONAL CARE;]

(4) [(5)] "hospital" **may** [MUST] be defined **in relation to its status, facilities, and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the medicare program.** [TO INCLUDE ANY FACILITY WHICH:]

[(A) IS OPERATED LAWFULLY AND ACCREDITATED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS;

(B) IS PRIMARILY AND CONTINUOUSLY ENGAGED IN PROVIDING OR OPERATING, EITHER ON ITS PREMISES OR IN FACILITIES AVAILABLE TO THE HOSPITAL, ON A PREARRANGED BASIS AND UNDER THE SUPERVISION OF A STAFF OF DULY LICENSED PHYSICIANS, MEDICAL, DIAGNOSTIC, AND MAJOR SURGICAL FACILITIES FOR THE MEDICAL CARE AND TREATMENT OF SICK OR INJURED PERSONS ON AN INPATIENT BASIS FOR WHICH A CHARGE IS MADE; AND

(C) PROVIDES 24-HOUR NURSING SERVICE BY OR UNDER THE SUPERVISION OF A REGISTERED GRADUATE PROFESSIONAL NURSE (R.N.);]

[(6) "HOSPITAL" MAY NOT BE DEFINED TO INCLUDE

(A) CONVALESCENT HOMES, OR CONVALESCENT, REST, OR NURSING FACILITIES;

(B) FACILITIES PRIMARILY AFFORDING CUSTODIAL, EDUCATIONAL, OR REHABILITORY CARE;

(C) FACILITIES FOR THE AGED, DRUG ADDICTS, OR ALCOHOLICS; OR

(D) ANY MILITARY OR VETERANS HOSPITAL OR SOLDIERS HOME OR ANY HOSPITAL CONTRACTED FOR OR OPERATED BY ANY NATIONAL GOVERNMENT FOR THE TREATMENT OF MEMBERS OR VETERANS OF THE ARMED FORCES, UNLESS THE SERVICES ARE RENDERED ON AN EMERGENCY BASIS AND THE INDIVIDUAL IS LEGALLY LIABLE FOR CHARGES MADE FOR THE MEDICAL SERVICES PROVIDED;]

(5) [(7)] each policy [OR SUBSCRIBER CONTRACT] must include a definition of "medicare" which refers to the federal law creating the medicare program;

(6) [(8)] "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 the insurance coverage is in force; however, injuries for which benefits are provided under any workers compensation, employer's liability or similar law may be excluded;

(7) [(9)] "medicare eligible expenses" must include [HEALTH CARE] expenses of the kind covered by medicare, to the extent recognized as reasonable **and medically necessary** by medicare[, BUT MAY BE CONDITIONED UPON THE SAME OR LESS-RESTRICTIVE PAYMENT CONDITIONS, INCLUDING DETERMINATIONS OF MEDICAL NECESSITY, AS ARE APPLICABLE TO MEDICAL CLAIMS];

[(10) "MENTAL DISORDERS" OR "NERVOUS DISORDERS" MUST INCLUDE NEUROSIS, PSYCHONEUROSIS, PSYCHOPATHY, PSYCHOSIS, OR MENTAL OR EMOTIONAL DISEASE OR DISORDER OF ANY KIND;]

[(11) "NURSE" MUST BE DEFINED TO INCLUDE ALL PERSONS LICENSED BY THE STATE AS A "NURSE" OR "REGISTERED NURSE";]

(8) [(12)] if the terms "qualified physician" or "licensed physician" are used, the insurer must accept, to the extent of its obligation under the policy [OR SUBSCRIBER CONTRACT], all services provided which are within the scope of the provider's licensed authority, **and shall not be defined more restrictively than as defined in the medicare program**;

(9) [(13)] "sickness" must be defined to include any disease or illness of a covered person which first manifests itself after the effective date of coverage and while the coverage is in force, but may exclude disease or illness for which benefits are provided under any workers compensation, occupational disease, employer's liability, or similar law;

(10) [(14)] "health care expenses" must mean expenses of a health maintenance organization associated with the delivery of health care services that are analogous to incurred losses of insurers; such expenses may not include

(A) home office and overhead costs;

(B) advertising costs;

(C) commissions and other acquisition costs;

(D) taxes;

(E) capital costs;

(F) administrative costs; or

(G) claims processing costs.

[(b) EACH MEDICARE SUPPLEMENT POLICY OR MEDICARE SUPPLEMENT SUBSCRIBER CONTRACT MUST INCLUDE A DEFINITION OF "MEDICARE" THAT REFERS TO THE FEDERAL LAW CREATING THE MEDICARE PROGRAM.] (Eff. 3/26/82, Register 81; am 8/8/90, Register 115; am __/__/__, Register __)

Authority: AS 21.06.090
AS 21.42.130
AS 21.89.060

3 AAC 28.440 is repealed and re-adopted to read:

3 AAC 28.440. POLICY PROVISIONS. (a) Except for permitted pre-existing condition clauses described in 3 AAC 28.450 and 3 AAC 28.453, a policy or certificate may not be advertised, solicited, or issued for delivery in this state as a medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of medicare.

(b) A medicare supplement policy or certificate in force in this state may not contain benefits that duplicate benefits provided by medicare.

(c) A medicare supplement policy or certificate may not exclude, limit, or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions.

(d) A medicare supplement policy or certificate may not contain the terms "Medicare Supplement," or "Medigap," nor words of similar import, unless the policy is issued in compliance with 3 AAC 28.410-3 AAC 28.510. (Eff. 3/26/82, Register 81; am 8/8/90, Register 115; am __/__/__, Register __)

Authority: AS 21.06.090

AS 21.42.130

AS 21.89.060

3 AAC 28.450 is amended to read:

3 AAC 28.450. MEDICARE SUPPLEMENT MINIMUM STANDARDS FOR POLICIES ISSUED PRIOR TO THE EFFECTIVE DATE OF 3 AAC 28.453. (a) A medicare supplement policy **issued prior to the effective date of 3 AAC 28.453** [OR MEDICARE SUPPLEMENT SUBSCRIBER CONTRACT] may not be advertised, solicited, or issued for delivery in this state[,] unless it meets the following minimum policy standards:

(1) a loss incurred more than six months after the effective date of coverage for a pre-existing condition must be covered;

(2) "pre-existing condition" may not be **more restrictively** defined **than** [TO INCLUDE] a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage;

(3) limitations of coverage with respect to pre-existing conditions must appear as a separate paragraph in the policy [OR SUBSCRIBER CONTRACT] and be labeled as "Pre-existing Condition Limitations";

(4) a sickness may not be covered on a different basis than a loss resulting from an accident;

(5) benefits designed to cover cost-sharing amounts under medicare must be changed automatically to coincide with any changes in the applicable medicare deductible amount and copayment

percentage factors, and the premiums charged may be changed to correspond with these changes;

(6) cancellation or nonrenewal may not be based solely on deterioration of health;

(7) other than for the nonpayment of premium, coverage provided to the spouse of the named insured through the same policy [OR SUBSCRIBER CONTRACT] may not be canceled or nonrenewed solely because of an occurrence or event which results in the termination of the named insured's coverage;

(8) renewal, continuation, or nonrenewal provisions must be contained in the policy or **certificate** [CONTRACT]:

(9) except for a rider or endorsement by which the insurer effectuates a request made in writing by an insured who exercises a specifically reserved right under a medicare supplement policy [OR SUBSCRIBER CONTRACT,] or a rider or endorsement that is required to reduce or eliminate benefits to avoid duplication of medicare benefits, a rider or endorsement added to a medicare supplement policy after the date of issue or at reinstatement or renewal that reduces or eliminates benefits or coverage in the policy requires a signed acceptance by the insured; after the date

of policy issuance, a rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in written form, signed by the insured, unless the benefits are required by the minimum standards for a medicare supplement insurance policy [OR SUBSCRIBER CONTRACT,] or the increased benefits or coverage are required by law; if a separate, additional, premium is charged for benefits provided in connection with a rider or endorsement, that premium charge shall be set out in the policy;

(10) termination must be without prejudice to any continuous loss which commenced while coverage was in force, but the extension of benefits beyond the period during which the policy or **certificate** [SUBSCRIBER CONTRACT] is in force may be predicated upon the continuous total disability of the insured and may be limited to the duration of the benefit period for payment of the maximum benefits;

(11) if benefits are based on standards described as "usual and customary," "reasonable and customary," or words of similar import, the terms must be defined in the policy or **certificate** [CONTRACT];

(12) the first page must notify the purchaser that the policy **or**[,] certificate, [OR SUBSCRIBER CONTRACT] may be unconditionally returned within 30 days after its delivery and the premium will be refunded;

(13) repealed 8/8/90.

(b) A medicare supplement policy **issued prior to the effective date of 3 AAC 28.453** [OR MEDICARE SUPPLEMENT SUBSCRIBER CONTRACT] may not be advertised, solicited, or issued for delivery in this state unless it meets the following minimum benefit standards:

(1) coverage of Part A medicare 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 Part A medicare eligible expenses incurred as daily hospital charges during use of medicare's lifetime hospital inpatient reserve days;

(3) upon exhaustion of all medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 90 percent of all medicare Part A eligible expenses for

hospitalization not covered by medicare, subject to a lifetime maximum benefit of an additional 365 days; [AND]

(4) coverage of 20 percent of the amount of medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar-year out-of-pocket deductible of $200 of these expenses and to a maximum benefit of at least $5,000 per calendar year;

(5) coverage for either all or none of the medicare Part A inpatient hospital deductible amount;

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

(7) coverage for the coinsurance amount of medicare-eligible expenses under Part B, regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the medicare Part B deductible ($100) [($75)] maximum benefit; **and**

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

(c) The standards enumerated in (a) and (b) of this section are required minimum standards and do not prohibit additional provisions or benefits which are not inconsistent with these standards.

(d) Except as authorized by the director of insurance, an insurer shall neither cancel nor nonrenew a medicare supplement policy [OR SUBSCRIBER CONTRACT] for any reason other than nonpayment of premium or material misrepresentation.

(e) Payment by insurers of benefits for medicare-eligible expenses may be conditioned upon the same less restrictive payment conditions, including determinations of medical necessity, as are applicable to medicare claims. (Eff. 3/26/82, Register 81; am 8/8/90, Register 115; am __/__/__, Register __)

Authority: AS 21.06.090

AS 21.42.130

AS 21.89.060

3 AAC 28.451 is amended to read:

3 AAC 28.451. TERMINATION BY GROUP POLICYHOLDER; CONVERSION. (a) If a group medicare supplement insurance policy [OR SUBSCRIBER CONTRACT] is terminated by the group policyholder and not replaced as described in (c) of this section, the **issuer** [INSURER, FRATERNAL BENEFIT SOCIETY, OR HOSPITAL OR MEDICAL SERVICE CORPORATION] shall offer each certificate holder an individual medicare supplement policy. The **issuer** [INSURER, FRATERNAL BENEFIT SOCIETY, OR HOSPITAL OR MEDICAL SERVICE CORPORATION] shall offer the certificate holder at least the following choices:

(1) an individual medicare supplement policy [OR SUBSCRIBER CONTRACT] that provides for continuation of the benefits contained in the group policy[;] **and**

(2) an individual medicare supplement policy [OR SUBSCRIBER CONTRACT] that provides only such benefits as are required to meet the minimum standards.

(b) If membership in a group is terminated, the **issuer** [INSURER, FRATERNAL BENEFIT SOCIETY, OR HOSPITAL OR MEDICAL SERVICE CORPORATION] shall

(1) offer the certificate holder the opportunity to convert to an individual policy that meets the minimum standards set out in 3 AAC 28.450(a)[;] or

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

(c) If a group medicare supplement policy [OR SUBSCRIBER CONTRACT] is replaced by another group medicare supplement policy [OR SUBSCRIBER CONTRACT] purchased by the same policyholder, the succeeding **issuer** [INSURER] shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy may not result in an exclusion for a pre-existing condition that would have been covered under the group policy being replaced. (Eff. 8/8/90, Register 115; am __/__/__, Register ___)

Authority: AS 21.06.090
AS 21.42.130
AS 21.89.060

3 AAC 28.452 is amended to read:

3 AAC 28.452. COMPLIANCE WITH 42 U.S.C. 1395ss (OMNIBUS BUDGET RECONCILIATION ACT OF 1990 [1987]). (a) A person who transacts the business of insurance and who provides medicare supplement policies [OR MEDICARE SUPPLEMENT SUBSCRIBER CONTRACTS] shall comply with all provisions of [42 U.S.C. 1395u and] 1395ss **as amended by the** [(]Omnibus Budget Reconciliation Act of **1990** [1987)].

(b) Certification of compliance with the requirements of (a) of this section must be in the form set out at the end of this subsection. The form must be completed in accordance with the following instructions:

MEDICARE SUPPLEMENT INSURANCE EXPERIENCE
EXHIBIT
For the year ended December 31, 19___
For the state of ________________________

Of the ____ insurance company
Address (city, state and zip code) ______________________________
NAIC Group Code ______________________ NAIC Company Code__________
Person Completing This Exhibit ___________________________________

To be filed by June 30 following the Annual Statement Filing

		Incurred Claims	
Classification	Premiums Earned	Amount	% of Premiums Earned
Experience on individual policies			

1. Policies issued through 19__
   Reporting state . . . .
   Nationwide . . . .

2. Policies issued through 19__
   Reporting state . . . .
   Nationwide . . . .

Experience on group policies
1. Policies issued through 19__
   Reporting state . . . .
   Nationwide . . . .

2. Policies issued through 19__
   Reporting state . . . .
   Nationwide . . . .

The undersigned officer hereby certifies that the company named above has complied with the requirements contained in **[**42 U.S.C. 1395u**]** and 1395ss **as amended by** **[**(**]**Omnibus Budget Reconciliation Act of **1990** **[**1987**]**.

____
Signature

____
Title and Name (Please Type)

(1) Experience on policies issued more than three years before the reporting year must be shown separately as indicated on the form. For example, for the reporting year ended 12/31/88 (filed on June 30, 1989), experience on policies issued in 1985 and earlier should be shown separately from that of policies issued in 1986 and later. For group insurance, the year of issue should be based on when the certificate was issued if available; otherwise use the master policy year of issue.

(2) Allocation of reserves on the state-by-state basis must be on sound actuarial principles and be consistent from year to year.

(3) Membership or policy fees, if any, must be included with premiums earned. Earned premiums may be shown on an annual basis net of loading for non-annual modes.

(4) Mass-marketed group insurance subject to individual loss ratio standards must be included with individual.

(5) Dividends must be included with incurred claims.

(6) Neither incurred claims nor earned premiums may be adjusted for changes in policy (additional) reserves.

(Eff. 8/8/90, Register 115; am __/__/__, Register __)

Authority: AS 21.06.090

AS 21.42.130

AS 21.89.060

3 AAC 28 is amended by adding a new section to read:

3 AAC 28.453. MINIMUM BENEFIT STANDARDS FOR POLICIES OR CERTIFICATES ISSUED IN THIS STATE ON OR AFTER THE EFFECTIVE DATE OF THIS SECTION. (a) Standards. The standards under this section are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state on or after the effective date of this section. A policy or certificate may not be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards.

(b) General Standards. The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of 3 AAC 28.410 - 3 AAC 28.510.

(1) a medicare supplement policy or certificate may not exclude or limit benefits for a loss incurred more than six months from the effective date of coverage because the loss involved a pre-existing condition; a policy or certificate may not define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage;

(2) a medicare supplement policy or certificate may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;

(3) a medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in applicable medicare deductible amount and copayment percentage factors; premiums may be modified to correspond with the changes;

(4) a medicare supplement policy or certificate may not 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) a medicare supplement policy must be guaranteed renewable and

(A) the issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual;

(B) the issuer may 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 under (E) of this paragraph, the issuer shall offer certificateholders an individual medicare supplement policy which, at the option of the certificateholder,

(i) provides for continuation of the benefits contained in the group policy, or

(ii) provides for benefits that otherwise meet the requirements of this subsection;

(D) if an individual is a certificateholder in a group medicare supplement policy and the individual terminates membership in the group, the issuer shall

(i) offer the certificateholder a conversion opportunity under (C) of this paragraph, or,

(ii) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy; or

(E) if a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination; coverage under the new policy may not result in any exclusion for pre-existing conditions that would have been covered under the group policy that is being replaced;

(6) termination of a medicare supplement policy or certificate shall be without prejudice to a continuous loss that 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;

(7) a medicare supplement policy or certificate shall provide benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed 24 months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, as amended, 42 U.S.C. 1396 - 1396u (medicaid) but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to the assistance; upon receipt of timely notice, the issuer shall return to the policyholder or certificateholder that portion of the premium attributable to the period of medicaid eligibility, subject to adjustments for paid claims;

(8) if suspension occurs under paragraph (7) and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated as of the date of the termination of the entitlement if the policyholder or certificateholder provides notice of loss of

the entitlement within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of the entitlement; and

(9) reinstatement of the coverages

(A) may not provide for any waiting period with respect to treatment of pre-existing conditions;

(B) must provide for coverage that is substantially equivalent to coverage in effect before the date of the suspension; and

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

(c) Standards for Basic ("Core") Benefits Common to All Benefit Plans. An issuer shall make available a policy or certificate including only the basic "core" package of benefits to a prospective insured. An issuer may make available to a prospective insured any of the other medicare supplement insurance benefit plans in addition to the basic "core" package, but not in lieu of it. The basic "core" package shall contain:

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

(3) upon exhaustion of the medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Part A medicare eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

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

(5) coverage for the coinsurance amount of medicare eligible expenses under Part B regardless of hospital confinement, subject to the medicare Part B deductible.

(d) Standards for Additional Benefits. The following additional benefits shall be included in medicare supplement benefit plans "B" through "J" only as provided in 3 AAC 28.455(e):

(1) coverage for all of the medicare Part A inpatient hospital deductible amount per benefit period;

(2) 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 posthospital skilled nursing facility care eligible under medicare Part A;

(3) coverage for all of the medicare Part B deductible amount per calendar year regardless of hospital confinement;

(4) coverage for 80 percent of the difference between the actual medicare Part B charge as billed, not to exceed any charge limitation established by the medicare program or state law and the medicare-approved Part B charge;

(5) 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) coverage for 50 percent of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by medicare;

(7) coverage for 50 percent of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by medicare;

(8) coverage to the extent not covered by medicare for 80 percent of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, if the care would have been covered by medicare if provided in the United States and the care began during the first 60 consecutive days of a trip outside the United States, subject to a calendar year deductible of $250 and a lifetime maximum benefit of $50,000; for purposes of this benefit,

"emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset;

(9) coverage for the following preventative health services:

(A) an annual clinical preventive medical history and physical examination that may include tests and services from (B) of this paragraph and patient education to address preventive health care measures;

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

(i) fecal occult blood test and/or digital rectal examination;

(ii) mammogram;

(iii) dipstick urinalysis for hematuria, bacteriuria, and proteinuria;

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

(v) serum cholesterol screening, every five years;

(vi) thyroid function test; or

(vii) diabetes screening;

(C) influenza vaccine administered at any appropriate time during the year and Tetanus and Diphtheria booster, every ten years; and

(D) any other tests or preventative measures determined appropriate by the attending physician; reimbursement shall be for the actual charges up to 100 percent of the medicare-approved amount for each service, as though medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under the benefit; this benefit may not include payment for any procedure covered by medicare;

(10) coverage for services to provide short term at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery;

(A) for purposes of this benefit, the following definitions shall apply:

(i) "activities of daily living" include bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

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

(iii) "home" means a place used by an insured as a place of residence, if the place would qualify as a residence for home health care services covered by medicare; a hospital or skilled nursing facility may not be considered an insured's place of residence;

(iv) "at-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except that each consecutive four hours in a 24-hour period of services provided by a care provider is considered one visit;

(B) at-home recovery services provided must be primarily services which assist in activities of daily living;

(C) an 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;

(D) coverage is limited to

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

(ii) the actual charges for each visit up to a maximum reimbursement of $40 per visit;

(iii) $1,600 per calendar year;

(iv) seven visits in one week;

(v) care furnished on a visiting basis in an insured's home;

(vi) services provided by a care provider as defined in this section;

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

(viii) at-home recovery visits received during the period an insured is receiving medicare approved home care services or no more than 8 weeks after the service date of the last medicare approved home health care visit;

(E) coverage is excluded for

(i) home care visits paid for by medicare or other government programs and

(ii) care provided by family members, unpaid volunteers, or providers who are not care providers; and

(F) an issuer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards; the new or innovative benefits may include benefits that are appropriate to medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of medicare supplement policies. (Eff. __/__/__, Register ____)

Authority: AS 21.06.090
AS 21.42.130
AS 21.89.060

3 AAC 28 is amended by adding new sections to read:

3 AAC 28.455. STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS. (a) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits defined under 3 AAC 28.453(c).

(b) A group, package, or combination of medicare supplement benefits not listed in this section may not be offered for sale in this state, except as permitted under 3 AAC 28.453(d)(10)(F) and 3 AAC 28.456.

(c) Benefit plans must be uniform in structure, language, designation, and format to the standard benefit plans "A" through "J" listed in this subsection and conform to the definitions under 3 AAC 28.430 and 3 AAC 28.510. A benefit must be structured in accordance with the format under 3 AAC 28.453(c) and (d) and list the benefits in the order shown. For purposes of this section, "structure, language, and format" mean style, arrangement, and overall content of a benefit.

(d) An issuer may use, in addition to the benefit plan designations required in (c) of this section, other designations to the extent permitted by law.

(e) Benefit plans must adhere to the following requirments:

(1) standardized medicare supplement benefit plan "A" shall be limited to the basic ("Core") benefits common to all benefit plans, as defined in 3 AAC 28.453(c);

(2) standardized medicare supplement benefit plan "B" shall consist of the core benefit as defined in 3 AAC 28.453(c) plus the medicare Part A deductible as defined in 3 AAC 28.453(d)(1);

(3) standardized medicare supplement benefit plan "C" shall consist of the core benefit as defined in 3 AAC 28.453(c) 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 3 AAC 28.453(d)(1), (2), (3), and (8);

(4) standardized medicare supplement benefit plan "D" shall consist of the core benefit as defined in 3 AAC 28.453(c)

plus the medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in 3 AAC 28.43(d)(1), (2), (8), and (10);

(5) standardized medicare supplement benefit plan "E" shall consist of the core benefit as defined in 3 AAC 28.45(c) plus the medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in 3 AAC 28.453(d)(1), (2), (8), and (9);

(6) standardized medicare supplement benefit plan "F" shall consist of the core benefit as defined in 3 AAC 28.453(c) plus the medicare Part A deductible, skilled nursing facility care, the Part B deductible, all of the medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in 3 AAC 28.453(d)(1), (2), (3), (5), and (8);

(7) standardized medicare supplement benefit plan "G" shall consist of the core benefit as defined in 3 AAC 28.453(c) plus the medicare Part A deductible, skilled nursing facility care, 80 percent of the medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home

recovery benefit as defined in 3 AAC 28.453(d)(1), (2), (4), (8), and (10);

(8) standardized medicare supplement benefit plan "H" shall consist of the core benefit as defined in 3 AAC 28.453(c) plus the medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as defined in 3 AAC 28.453(d)(1), (2), (6), and (8);

(9) standardized medicare supplement benefit plan "I" shall consist of the core benefit as defined in 3 AAC 28.453(c) plus the medicare Part A deductible, skilled nursing facility care, all of the medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in 3 AAC 28.453(d)(1), (2), (5), (6), (8), and (10); and

(10) standardized medicare supplement benefit plan "J" shall consist of the core benefit as defined in 3 AAC 28.453(c) plus the medicare Part A deductible, skilled nursing facility care, medicare Part B deductible, all of the medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and

at-home recovery benefit as defined in 3 AAC 28.453(d)(1), (2), (3), (5), (7), (8), (9), and (10). (Eff. __/__/__, Register __)

Authority: AS 21.06.090

AS 21.42.130

AS 21.89.060

3 AAC 28.456. MEDICARE SELECT POLICIES AND CERTIFICATES. (a) This section applies to medicare select policies and certificates. A policy or certificate may not be advertised as a medicare select policy or certificate unless it meets the requirements of this section.

(b) For the purposes of this section

(1) "complaint" means a 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" and "medicare select certificate" mean a medicare supplement policy or certificate, respectively, that contains restricted network provisions;

(5) "network provider" means a provider of health care that has entered into a written agreement with the issuer to provide benefits insured under a medicare select policy;

(6) "restricted network provision" means a provision that 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 director within which an issuer is authorized to offer a medicare select policy.

(c) The director may authorize an issuer to offer a medicare select policy or certificate under this section and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, 42 U.S.C. § 1395ss, if the director finds that the issuer has satisfied all of the requirements of 3 AAC 28.410 - 3 AAC 28.510 and that sale of such policies is in the public interest.

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

(e) A medicare select issuer shall file a proposed plan of operation with the director in a format prescribed by the director. The plan of operation must contain at least

(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) the 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 must reflect usual practice in the local area; geographic availability must reflect the usual travel times within the community;

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

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

(ii) to make appropriate referrals;

(C) there are written agreements with network providers describing specific responsibilities;

(D) emergency care is available 24 hours per day and seven days per week; and

(E) in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a medicare select policy or certificate; this subparagraph does 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 (i) of this section; and

(7) any other information requested by the director.

(f) A medicare select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the director prior to implementing the changes. The changes shall be considered approved by the director after 30 days unless specifically disapproved. An updated list of network providers shall be filed with the director at least quarterly.

(g) A medicare select policy or certificate may 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 condition and

(2) it is not reasonable to obtain the services through a network provider.

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

(i) A medicare select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the medicare select policy or certificate to each applicant. The disclosure shall include at least

(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;

(4) a description of coverage for emergency and urgently needed care and other out-of-service-area coverage;

(5) a description of limitations on referrals to restricted network providers and to other providers;

(6) a description of the policyholder's rights to purchase any other medicare supplement policy or certificate otherwise offered by the issuer; and

(7) a description of the medicare select issuer's quality assurance program and grievance procedure.

(j) Prior to the sale of a medicare select policy or certificate, a medicare select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to (i) of this section and that the applicant understands the restrictions of the medicare select policy or certificate.

(k) A medicare select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures. The grievance procedures shall be consistent with the following standards:

(1) the grievance procedure must 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 filed 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; and

(6) the issuer shall file a report no later than each March 31st to the director on its grievance procedure; the report shall be in a format prescribed by the director and shall contain

the number of grievances filed in the past year and a summary of the subject, nature, and resolution of the grievances.

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

(m) At the request of an individual insured under a medicare select policy or certificate, a medicare select issuer shall make available to an individual insured the opportunity to purchase a medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision. An issuer shall make the policies or certificates available without requiring evidence of insurability after the medicare supplement policy or certificate has been in force for six months. For the purposes of this subsection, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefit not included in the medicare select policy or certificate being replaced and a "significant benefit" means coverage for the medicare Part A deductible, coverage of prescription drugs, coverage for at-home recovery services, or coverage for Part B excess charges.

(n) medicare select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that medicare select policies and certificates issued under this section should be discontinued due to either the failure of the medicare select program to be reauthorized under law or its substantial amendment. A medicare select issuer shall make available to an individual insured under a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision. An issuer shall make the policies and certificates available without requiring evidence of insurability. For the purposes of this subsection, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the medicare select policy or certificate being replaced and a "significant benefit" means coverage for the medicare Part A deductible, coverage of prescription drugs, coverage for at-home recovery services, or coverage for Part B excess charges.

(o) A medicare select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the medicare select program. (Eff. __/__/__, Register ___)

Authority: AS 21.06.090

AS 21.42.130

AS 21.89.060

3 AAC 28.457. OPEN ENROLLMENT: (a) An issuer may not deny or condition the issuance or effectiveness of a medicare supplement policy or certificate available for sale in this state, or discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for the policy or certificate is submitted during the six month period beginning with the first month in which an individual, who is 65 years of age or older, first enrolled for benefits under medicare Part B. A medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

(b) The terms of (a) of this section may not be construed to prevent the exclusion of benefits under a policy during the first six months based on a pre-existing condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six months before it became effective. (Eff. __/__/__, Register ___)

Authority: AS 21.06.090
AS 21.42.130
AS 21.89.060

3 AAC 28.458. 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 a notice from a medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) notifying the participating physician or supplier and the beneficiary of the payment determination;

(3) paying the participating physician or supplier directly;

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

(5) paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) providing at least annually to the Secretary of Health and Human Services a central mailing address to which all claims may be sent by medicare carriers.

(b) Compliance with the requirements of (a) of this section shall be certified on the medicare supplement insurance experience reporting form. (Eff. __/__/__, Register __)

Authority: AS 21.06.090
AS 21.42.130
AS 21.89.060

3 AAC 28.460 is repealed and re-adopted to read:

3 AAC 28.460. LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM. (a) A medicare supplement policy form or certificate form may not be delivered or issued for delivery unless the policy 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 certificateholders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy or certificate form

(1) at least 75 percent of the aggregate amount of premiums earned in the case of group policies or

(2) at least 65 percent of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices.

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

(c) For purposes of applying (a)(1) of this section and 3 AAC 28.472(d) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising, including both print and broadcast advertising, shall be deemed to be individual policies.

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

(e) 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.

(f) 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 may include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event may 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. (Eff. 3/26/82, Register 81; am 8/8/90, Register 115; am __/__/__, Register __)

Authority: AS 21.06.090
AS 21.42.130
AS 21.89.060

3 AAC 28.470 is repealed and re-adopted to read:

3 AAC 28.470. FILINGS. (a) An issuer of medicare supplement policies and certificates shall file annually its forms, rates, rating schedule, and supporting documentation, including ratios of incurred losses to earned premiums by policy duration, for approval by the director. Supporting documentation shall demonstrate in accordance with accepted actuarial practices and using reasonable assumptions that the appropriate loss ratio standards under 3 AAC 28.460 can be expected to be met over the entire period for which rates are computed, excluding active life reserves. An expected third-year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

(b) As soon as practicable, but prior to the effective date of enhancements in medicare benefits, an issuer of medicare supplement policies or certificates in this state shall file with the director appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment to produce loss ratios required by 3 AAC 28.460(a) shall accompany the filing. An issuer shall make premium adjustments necessary to produce an expected loss ratio under a policy or certificate that will conform with 3 AAC 28.460 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. A premium adjustment that would modify the loss ratio experience under the policy other than the adjustments described in this section may not be made with respect to a policy at any time other than upon its renewal date or anniversary date.

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

(d) The director may conduct a public hearing on an increase in a rate for a policy form or certificate form 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 shall be made without consideration of any refund or credit for the reporting period. Notice of a hearing shall be published in a newspaper of general circulation and given in accordance with AS 21.06.200. (Eff. 3/26/82, Register 81; am 8/8/90, Register 115; am __/__/__, Register __)

Authority: AS 21.06.090
AS 21.06.200
AS 21.42.120
AS 21.42.130
AS 21.84.300
AS 21.87.180
AS 21.89.060

3 AAC 28.471 is repealed:

3 AAC 28.471. FILING REQUIREMENTS FOR OUT-OF-STATE GROUP POLICIES. Repealed ___/___/___.

3 AAC 28 is amended by adding a new section to read:

3 AAC 28.472. FILING AND APPROVAL OF POLICIES, CERTIFICATES, AND PREMIUM RATES. (a) An issuer may not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy or certificate form has been filed with and approved by the director.

(b) An issuer may not use or change premium rates for a medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the director.

(c) An issuer may not file for approval more than one form of a policy or certificate of each type for each standard medicare supplement benefit plan except that with the approval of the director, an issuer may offer up to four additional policy forms or certificate forms of the same type for the same standard medicare supplement benefit plan, one for each of the following:

(1) the inclusion of new or innovative benefits;

(2) the addition of either direct response or agent marketing methods;

(3) the addition of either guaranteed issue or underwritten coverage; and

(4) the offering of coverage to individuals eligible for medicare by reason of disability.

(d) For purposes of this section, a "type" means an individual policy, a group policy, an individual medicare select policy, or a group medicare select policy.

(e) Except as provided in (f) of this section, an issuer shall continue to make available for purchase any policy or certificate form issued after the effective date of this regulation that has been approved by the director. A policy or certificate form shall be considered to be available for purchase if the issuer has actively offered it for sale in the previous 12 months.

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

(g) An issuer that discontinues the availability of a policy or certificate form under (f) of this section may not file for approval a new policy or certificate form of the same type for the same standard medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

(h) The sale or other transfer of medicare supplement business to another issuer shall be considered a discontinuance for purposes of this section.

(i) A change in the rating structure or methodology shall be considered a discontinuance under this section unless the issuer

(1) provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which

the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates and

(2) 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, but the director may approve a change to the differential that is in the public interest.

(j) Except as provided in (k) of this section, the experience of all policy 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 under 3 AAC 28.460.

(k) Forms assumed under an assumption reinsurance agreement may not be combined with the experience of other forms for purposes of the refund or credit calculation. (Eff. ___/___/___, Register ___)

Authority: AS 21.06.090
AS 21.42.130
AS 21.89.060

3 AAC 28.490 is repealed and re-adopted to read:

3 AAC 28.490. REQUIRED DISCLOSURE PROVISIONS. (a) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provisions shall be consistent with the type of contract issued. The provisions shall be appropriately captioned, shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

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

(c) A medicare supplement policy or certificate may not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

(d) If a medicare supplement policy or certificate contains a limitation with respect to a pre-existing condition, the limitation shall appear as a separate paragraph of the policy and be labeled "pre-existing condition limitation."

(e) A medicare supplement policy or certificate shall have a notice prominently printed on the first page of the policy or certificate or attached to it stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(f) An issuer of accident and sickness policies, or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to a person eligible for medicare by reason of age shall provide to the applicant a medicare supplement buyer's guide in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12 point type. Delivery of the buyer's guide shall be made whether or not the policies or certificates are advertised, solicited, or issued as medicare supplement policies or certificates under 3 AAC 28.410 - 3 AAC 28.510. Except in the case of direct response issuers, delivery of the buyer's guide shall be made to the applicant at the time of application and acknowledgment of receipt of the buyer's guide shall be obtained by the issuer. Direct response issuers shall deliver the buyer's guide to the applicant upon request, but not later than at the time the policy is delivered.

(g) As soon as practicable, but not later than 30 days prior to the annual effective date of a medicare benefit change, an issuer shall notify its policyholders and certificateholders of modifications the issuer has made to medicare supplement insurance policies or certificates in a format acceptable to the director. The notice shall

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

(2) inform the policyholder or certificateholder when a premium adjustment is to be made due to changes in medicare.

(h) The notice of benefit modifications and premium adjustments shall be in outline form, in clear and simple terms, to facilitate comprehension.

(i) The notice may not contain or be accompanied by any solicitation.

(j) An issuer shall provide an outline of coverage to an applicant at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant.

(k) If an outline of coverage is provided at the time of application and the medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no smaller than 12 point type, immediately above the company name:

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

(l) The outline of coverage provided to an applicant under this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no smaller than 12 point type. Plans A-J shall be shown on the cover page and the plans 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 each plan that is offered to the prospective applicant. Each possible premium for the prospective applicant shall be illustrated.

(m) The following items shall be included in the outline of coverage in the order prescribed below.

[COMPANY NAME]

Outline of Medicare Supplement Coverage—Cover Page:
Benefit Plan(s) _____ [insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only ten standard plans. This chart shows the benefits included in each plan. Every company must make available Plan "A." Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses).
Blood: First three pints of blood each year.

A	B	C	D	E	F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (100%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)
				Preventive Care					Preventive Care

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.

A. [for agents]

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

B. [for direct response:]

[insert company's name] is not connected with medicare.

This outline of coverage does not give all the details of medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" 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. As issuer may use additional benefit plan designations on these charts pursuant to 3 AAC 28.455(d).]

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$0	$628 (Part A Deductible)
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	$0	Up to $78.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN A

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

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

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

PARTS A & B

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	$0	Up to $78.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN B

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

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

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

PARTS A & B

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

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out patient drugs and inpatient respite care	$0	Balance

PLAN C

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

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

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

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 a day $0	
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN D

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

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

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

(continued)

PLAN D (continued)

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements,including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN E

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

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

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

PARTS A & B

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

(continued)

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN F

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

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

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

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN 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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN G

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

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

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

(continued)

PLAN G (continued)

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN H

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements,including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN H

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

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

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

PARTS A & B

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

(continued)

PLAN H (continued)

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

PLAN I

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN I

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

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

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

(continued)

PLAN I (continued)

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges*	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

PLAN J

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN J

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

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

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

PARTS A & B

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

(continued)

PARTS A & B (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care beginning during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50%—$3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All Costs
PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diptheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All Costs

(Eff. 3/26/82, Register 81; am 8/8/90, Register 115; am __/__/__, Register __)

Authority: AS 21.06.090
AS 21.42.130
AS 21.89.060

3 AAC 28.491 is repealed:

3 AAC 28.491. DISCLOSURE REQUIREMENTS TO POLICY HOLDERS. Repealed ___/___/___.

3 AAC 28.500 is repealed and re-adopted to read:

3 AAC 28.500. 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 has another medicare supplement or other health insurance policy or certificate in force or whether a medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing the questions and statements may be used.

[Statements]

(1) You do not need more than one medicare supplement policy.

(2) If you are 65 or older, you may be eligible for benefits under medicaid and may not need a medicare supplement policy.

(3) The benefits and premiums under your medicare supplement policy will be suspended during your entitlement to benefits under medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for medicaid. If you are no longer entitled to medicaid, your policy will be reinstituted if requested within 90 days of losing medicaid eligibility.

(4) Counseling services may be available in your state to provide advice concerning your purchase of medicare supplement insurance and concerning medicaid.

[Questions]

To the best of your knowledge,

(1) Do you have another medicare supplement policy or certificate in force (including health care service contract, health maintenance organization contract)? If so, with which company?

(2) Do you have any other health insurance policies that provide benefits which this medicare supplement policy would duplicate?

(a) If so, with which company?

(b) What kind of policy?

(3) If the answer to question 1 or 2 is yes, do you intend to replace these medical or health policies with this policy [certificate]?

(4) Are you covered by medicaid?

(b) Agents shall list any other health insurance policies they have sold to the applicant as follows:

(1) list policies sold which are still in force and

(2) list policies sold in the past five 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 insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

(d) Upon determining that a sale will involve replacement of medicare supplement coverage, an issuer, other than a direct response issuer or its agent, shall furnish the applicant, prior to issuance or delivery of the medicare supplement policy or certificate, a notice regarding replacement of medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the 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 required under (d) of this section for an issuer shall be provided in substantially the following form in no less than ten point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. 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. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

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

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) (check one):

_______ Additional benefits.
_______ No change in benefits, but lower premiums.
_______ Fewer benefits and lower premiums.
_______ Other. (please specify)
____
____
____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If, you 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 company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, 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.

(f) The first two paragraphs of the replacement notice (applicable to pre-existing conditions) may be deleted by an issuer if the replacement does not involve application of a new pre-existing condition limitation.

(Eff. 3/26/82, Register 81; am 8/8/90, Register 115; am __/__/__, Register ___)

Authority: AS 21.06.090

AS 21.42.130

AS 21.89.060

3 AAC 28.501 is amended to read:

3 AAC 28.501. PERMITTED COMPENSATION ARRANGEMENTS. (a) An **issuer or other entity** [INSURER, FRATERNAL BENEFIT SOCIETY, OR HOSPITAL OR MEDICAL SERVICE CORPORATION] may provide a commission or other compensation to an agent or other representative for the sale of a medicare supplement policy[,] **or certificate** [SUBSCRIBER CONTRACT, OR MEDICARE SUPPLEMENT SUBSCRIBER CONTRACT] only if the first-year commission or other first-year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or **certificate** [SUBSCRIBER CONTRACT] in the second year or period.

(b) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period[,] and must be provided for **no fewer than five** [A REASONABLE NUMBER OF] renewal years.

(c) No **issuer or other** entity may provide compensation to its agents or other producers, and no agent or producer may receive compensation greater than the renewal compensation payable by the replacing **issuer** [INSURER, FRATERNAL BENEFIT SOCIETY OR HOSPITAL, OR MEDICAL SERVICE CORPORATION,] on [THE] renewal policies or **certificates** [SUBSCRIBER CONTRACTS] if an existing policy or **certificate** [SUBSCRIBER CONTRACT] is replaced [UNLESS BENEFITS OF THE NEW POLICY OR SUBSCRIBER CONTRACT ARE CLEARLY AND SUBSTANTIALLY GREATER THAN THE BENEFITS UNDER THE REPLACED POLICY OR SUBSCRIBER CONTRACT].

(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**, [SUBSCRIBER CONTRACT] including bonuses, gifts, prizes, awards, and finders fees. (Eff. 8/8/90, Register 115; am ___/___/___, Register ___)

Authority: AS 21.06.090

AS 21.42.130

AS 21.89.060

3 AAC 28.502 is amended to read:

3 AAC 28.502. NOTICE REGARDING POLICIES OR <u>CERTIFICATES</u> [SUBSCRIBER CONTRACTS] THAT ARE NOT MEDICARE SUPPLEMENT POLICIES. A disability insurance policy or **<u>certificate</u>** [SUBSCRIBER CONTRACT], other than a medicare supplement policy, or a policy issued under a contract under sec. 1876 of the Federal Social Security Act (42 U.S.C. 1395 et seq.); disability income policy or **<u>certificate</u>** [SUBSCRIBER CONTRACT]; basic, catastrophic, or major medical expense policy; or single premium non-renewable policy, shall notify insureds under the policy or **<u>certificate</u>** [SUBSCRIBER CONTRACT] that the policy or **<u>certificate</u>** [SUBSCRIBER CONTRACT] is not a medicare supplement policy [OR MEDICARE SUPPLEMENT SUBSCRIBER CONTRACT]. The notice shall either be printed on or attached to the first page of the outline of coverage delivered to the insured under the policy or **<u>certificate</u>** [SUBSCRIBER CONTRACT], or, if no outline of coverage is delivered, to the first page of the policy[,] **<u>or</u>** certificate[, OR SUBSCRIBER CONTRACT] delivered to the insured. The notice shall be in no less than 12-point type and shall contain the following language:

> "THIS (POLICY[,] OR CERTIFICATE[, OR SUBSCRIBER CONTRACT] IS NOT A MEDICARE SUPPLEMENT POLICY [OR MEDICARE SUBSCRIBER CONTRACT]). If you are eligible for medicare, review the medicare supplement buyer's guide available from the company."

(Eff. 8/8/90, Register 115; am ___/___/___, Register ___)

Authority: AS 21.06.090

AS 21.42.130

AS 21.89.060

3 AAC 28.503 is amended to read:

3 AAC 28.503. FILING REQUIREMENTS FOR ADVERTISING. **An issuer** [EVERY INSURER, FRATERNAL BENEFIT SOCIETY, AND HOSPITAL OR MEDICAL SERVICE ORGANIZATION PROVIDING MEDICARE SUPPLEMENT INSURANCE OR MEDICARE SUPPLEMENT SUBSCRIBER CONTRACTS] shall **provide** [FILE] a copy of any medicare supplement advertisement intended for use in this state, whether through written, radio, or television medium, for review **and approval** by the **director** [DIVISION]. (Eff. 8/8/90, Register 115; am __/__/__, Register __)

Authority: AS 21.06.090

AS 21.42.130

AS 21.89.060

3 AAC 28.504 is amended to read:

3 AAC 28.504. STANDARDS FOR MARKETING. (a) **An issuer** [EVERY INSURER, FRATERNAL BENEFIT SOCIETY OR HOSPITAL OR MEDICAL SERVICE

CORPORATION MARKETING MEDICARE SUPPLEMENT INSURANCE COVERAGE IN THIS STATE,] directly or through its producers, shall

(1) establish marketing procedures to **assure** [ASSUME] that any comparison of policies [OR SUBSCRIBER CONTRACTS] by **its** [THEIR] agents or other producers will be fair and accurate.

(2) establish marketing procedures **to assure** [THAT ENSURE THAT] excessive insurance is not sold or issued.

(3) display prominently by type, stamp, or other appropriate means, on the first page of the [OUTLINE OF COVERAGE AND] policy [OR SUBSCRIBER CONTRACT], the following:

> Notice to buyer: This policy [OR SUBSCRIBER CONTRACT MIGHT] **may** not cover all of **your** [THE COSTS ASSOCIATED WITH] medical **expenses** [CARE INCURRED BY THE BUYER DURING THE PERIOD OF COVERAGE. THE BUYER IS ADVISED TO REVIEW CAREFULLY ALL POLICY OR SUBSCRIBER CONTRACT LIMITATIONS].

(4) inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for medicare supplement insurance already has **accident and sickness** [DISABILITY] insurance[,] and the types and amounts of the insurance.

(5) establish auditable procedures for verifying compliance with this subsection.

(b) In addition to the practices prohibited in AS 21.36, the following acts and practices are prohibited:

(1) 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;

(2) making use, directly or indirectly, of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent, broker, **or issuer** [INSURER, FRATERNAL BENEFIT SOCIETY, OR HOSPITAL OR MEDICAL SERVICE CORPORATION].

(c) The terms "medicare supplement," "medigap," "medicare wrap-around" and words of similar import may not be used unless the policy is issued in compliance with 3 AAC 28.410 - 3 AAC 28.510. (Eff. 8/8/90, Register 115; am __/__/__, Register __)

Authority: AS 21.06.090

AS 21.42.130

AS 21.89.060

3 AAC 28.505 is amended to read:

3 AAC 28.505. APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE. (a) In recommending the purchase or replacement of a medicare supplement policy [OR SUBSCRIBER CONTRACT], an agent or broker shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(b) A sale of medicare supplement coverage which will provide an individual with more than one medicare supplement policy [OR SUBSCRIBER CONTRACT] is prohibited. [HOWEVER, ADDITIONAL MEDICARE SUPPLEMENT COVERAGE MAY BE SOLD IF, WHEN COMBINED WITH THAT INDIVIDUAL'S HEALTH COVERAGE ALREADY IN FORCE, IT WOULD INSURE NOT MORE THAN 100 PERCENT OF THE INDIVIDUAL'S ACTUAL MEDICAL EXPENSES COVERED UNDER THE COMBINED POLICIES OR SUBSCRIBER CONTRACTS]. (Eff. 8/8/90, Register 115; am ___/___/___, Register ___)

Authority: AS 21.06.090
AS 21.42.130
AS 21.89.060

3 AAC 28.506 is amended to read:

3 AAC 28.506. REPORTING OF MULTIPLE POLICIES. (a) Annually, on or before March 1, every **issuer** [INSURER, FRATERNAL BENEFIT SOCIETY, HOSPITAL OR MEDICAL SERVICE CORPORATION,] or other entity providing medicare supplement insurance coverage in this state shall report the following information for every individual resident of this state for which the **issuer** [INSURER, FRATERNAL BENEFIT SOCIETY, HOSPITAL, OR MEDICARE SERVICE CORPORATION,] or other entity has in force more than one medicare supplement insurance policy[, SUBSCRIBER CONTRACT,] or certificate:

(1) policy and subscriber control number, and

(2) date of issuance.

(b) The information required by (a) of this section must be grouped by individual policyholder. (Eff. 8/8/90, Register 115; am ___/___/___, Register ___).

Authority: AS 21.06.090
AS 21.42.130
AS 21.89.060

3 AAC 28.507 is amended to read:

3 AAC 28.507. PROHIBITION AGAINST PRE-EXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS, AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR [IN SUBSCRIBER CONTRACTS OR] CERTIFICATES. **(a)** If a medicare supplement policy or **certificate** [SUBSCRIBER CONTRACT] replaces another medicare supplement policy or **certificate** [SUBSCRIBER CONTRACT], the replacing **issuer** [INSURER, FRATERNAL BENEFIT SOCIETY, OR HOSPITAL OR MEDICAL SERVICE CORPORATION] shall waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, and probationary periods in the new medicare supplement policy or **certificate** [SUBSCRIBER CONTRACT] for similar benefits to the extent that that time was spent under the original policy [OR SUBSCRIBER CONTRACT].

(b) If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate that has been in effect for at least six months, the replacing policy may not provide any time period applicable to pre-existing conditions,

waiting periods, elimination periods, and probationary periods for benefits similar to those contained in the original policy or certificate. (Eff. 8/8/90, Register 115; am ___/___/___, Register ___).

Authority: AS 21.06.090
AS 21.42.130
AS 21.89.060

3 AAC 28.510 is amended to read:

3 AAC 28.510. DEFINITIONS. For purposes of 3 AAC 28.410 - 3 AAC 28.510:

(1) "applicant" means

(A) for an individual medicare supplement policy [OR INDIVIDUAL MEDICARE SUPPLEMENT SUBSCRIBER CONTRACT], the person who seeks to contract for **insurance benefits** [THE COVERAGE], and

(B) for a group medicare supplement policy [OR GROUP MEDICARE SUPPLEMENT SUBSCRIBER CONTRACT], **the proposed**

certificateholder [THE PERSON AUTHORIZED TO CONTRACT FOR THE COVERAGE FOR THE GROUP OF INDIVIDUALS TO BE COVERED];

(2) "certificate" means a certificate **delivered or** issued **for delivery in this state** under a group medicare supplement policy [OR GROUP MEDICARE SUPPLEMENT SUBSCRIBER CONTRACT DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE];

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

(4) "issuer" means an insurance company, fraternal benefit society, health care service plan, health maintenance organization, or other entity delivering or issuing for delivery in this state a medicare supplement policy or certificate;

(5)[(3)] "medicare" means Title I, Part I of Public Law 89-97, as enacted by the Eighty-Ninth Congress of the United States of America (popularly known as the Health Insurance for the Aged Act);

(6)[(4)] "medicare supplement policy" means a group or individual policy of [DISABILITY] insurance **or a subscriber contract**, [ISSUED BY AN INSURER OR FRATERNAL BENEFIT SOCIETY,] which is advertised, marketed, or designed primarily as a supplement to reimbursement under medicare for the hospital, medical, **or** [AND] surgical expenses of a person eligible for medicare [BY REASON OF AGE]; this term does not include

(A) 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 any combination of these, for employees or former employees, or any combination of these, of the labor organizations; or

(B) a policy or contract of any professional, trade, or occupational association for its members, former or retired members, or any combination of these, if the association

(i) is comprised of individuals all of whom are actively engaged in the same profession, trade, or occupation;

(ii) has been maintained in good faith for purposes other than obtaining insurance; and

(iii) has been in existence for at least two years before the date of the initial offering of this policy, contract, or plan to its members; or

(C) a policy **issued pursuant to a** [OR] contract **under Section 1876 or Section 1833 of the federal Social Security Act (42 U.S.C. Section 1395 et. seq.) or an issued policy under a demonstration project authorized pursuant to amendments to the federal Social Security Act** [DEFINED IN 3 AAC 28.420(b)]; [AND]

[(5) "MEDICARE SUPPLEMENT SUBSCRIBER CONTRACT" MEANS A GROUP OR INDIVIDUAL SUBSCRIBER CONTRACT, ISSUED BY A HOSPITAL OR MEDICAL SERVICE CORPORATION, WHICH IS ADVERTISED, MARKETED, OR DESIGNED PRIMARILY AS A SUPPLEMENT TO REIMBURSEMENT UNDER MEDICARE FOR THE HOSPITAL, MEDICAL, AND SURGICAL EXPENSES OF A PERSON ELIGIBLE FOR MEDICARE BY REASON OF AGE; THIS TERM DOES NOT INCLUDE

(A) A SUBSCRIBER 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 ANY COMBINATION OF THESE, FOR EMPLOYEES OR FORMER EMPLOYEES, OR ANY COMBINATION OF THESE; OF THE LABOR ORGANIZATION; OR

(B) A SUBSCRIBER CONTRACT OF ANY PROFESSIONAL, TRADE, OR OCCUPATIONAL ASSOCIATION FOR ITS MEMBERS, FORMER OR RETIRED MEMBERS, OR ANY COMBINATION OF THESE, IF THE ASSOCIATION

(i) IS COMPRISED OF INDIVIDUALS ALL OF WHOM ARE ACTIVELY ENGAGED IN THE SAME PROFESSION, TRADE, OR OCCUPATION;

(ii) HAS BEEN MAINTAINED IN GOOD FAITH FOR PURPOSES OTHER THAN OBTAINING COVERAGE; AND

(iii) HAS BEEN IN EXISTENCE FOR AT LEAST TWO YEARS BEFORE THE DATE OF THE INITIAL OFFERING OF THIS SUBSCRIBER CONTRACT TO ITS MEMBERS; OR

(C) A SUBSCRIBER CONTRACT DEFINED IN 3 AAC 28.420(b);]

(7)[(6)] "claim reserves" include only those unpaid liabilities for claims that have already been incurred;

(8)[(7)] "incurred claims" means paid claims plus the increase in claim reserves; "incurred claims" do not include policy (additional) reserves.

(9) "policy form" means the form on which a policy is delivered or issued for delivery by an insurer. (Eff. 3/26/82, Register 81; am 8/8/90, Register 115; am __/__/__, Register __).

Authority: AS 21.06.090

AS 21.42.130

AS 21.89.060

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM

FOR CALENDAR YEAR __________

TYPE ______________________ SMSBP (w)______________________

For the State of ______________________

Company Name ______________________

NAIC Group Code _________ NAIC Company Code ______________________

Address ______________________

Person Completing This Exhibit ______________________

Title ______________ Telephone Number______________________

line		(a) Earned Premium (x)	(b) Incurred Claims(y)
1	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues (z)		
	c. Net (for reporting purposes = 1a - 1b)	------------	------------
2	Past Years' Experience (All Policy Years)	------------	------------
3	Total Experience (Net Current Year + Past Years' Experience)	------------	------------
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		

$$\frac{\text{Total Actual Incurred Claims (line 3, col b)}}{\text{Tot. Earned Prem.(line 3, col a) - Refunds Since Inception(line 6)}} = \text{Ratio 2}$$

9 Life Years Exposed Since Inception ______________

If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.

10 Tolerance Permitted (obtained from credibility table) _________

MEDICARE SUPPLEMENT REFUND CALCULATION FORM

FOR CALENDAR YEAR ________

TYPE ____________________ SMSBP (w)____________________

For the State of ____________________

Company Name ____________________

NAIC Group Code ________ NAIC Company Code ____________

Address ____________________

Person Completing This Exhibit ____________________

Title ____________ Telephone Number ____________________

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.

12 Adjusted Incurred Claims =

[Tot. 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) -

$$\frac{\text{Adjusted Incurred Claims (line 12)}}{\text{Benchmark Ratio (Ratio 1)}}$$

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 and/or credit against premiums to be used must be attached to this form.

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.

MEDICARE SUPPLEMENT REFUND CALCULATION FORM

FOR CALENDAR YEAR __________

TYPE ______________________________ SMSBP (w)______________________________

For the State of ____

Company Name ____

NAIC Group Code _________ NAIC Company Code ____________________

Address ____

Person Completing This Exhibit ____

Title ________________ Telephone Number____________________________

(w) "SMSBP" = Standardized Medicare Supplement Benefit Plan

(x) Includes modal loadings and fees charged.

(y) Excludes Active Life Reserves.

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

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

____

Date

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR GROUP POLICIES
FOR CALENDAR YEAR ______

TYPE ______________ SMSBP (p) ______________
FOR THE STATE OF ______________
Company Name ______________
NAIC Group Code ______ NAIC Company Code ______
Address ______________
Person Completing This Exhibit ______________
Title ______ Telephone Number ______

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o) Policy Year 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		0.8
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):

(a): 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.)

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

(o): 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.

(p): "SMSBP" = Standardized Medicare Supplement Benefit Plan

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

TYPE ____________________ SMSBP (p)____________
FOR THE STATE OF ______________________________
Company Name __________________________________
NAIC Group Code ________ NAIC Company Code ____________
Address _______________________________________
Person Completing This Exhibit ___________________
Title ______________ Telephone Number ____________

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o) Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.4
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):

(a): 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.)

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

(o): 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.

(p): "SMSBP" = Standardized Medicare Supplement Benefit Plan

APPENDIX B

FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES

Company 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 #	Date of Issuance

____
Signature

____
Name and Title (please type)

____
Date