SUBCHAPTER T. Minimum Standards for Medicare Supplement Policies
28 TAC §§3.3302 – 3.3308, 3.3312, 3.3316, 3.3317, and
3.3323 – 3.3325

Repeal of 28 TAC §3.3318

INTRODUCTION. The Texas Department of Insurance proposes amendments to 28 Texas Administrative Code §§3.3302 - 3.3308, 3.3312, 3.3316, 3.3317, and 3.3323 – 3.3325, and it proposes the repeal of 28 TAC §3.3318. These sections relate to Medicare supplement policies. These proposed amendments and repeal are necessary to implement the most recent revisions to the National Association of Insurance Commissioner's (NAIC) Medicare supplement insurance model regulation to comply with the Medicare Access and CHIP Reauthorization Act of 2015, Public Law 114-10, at 42 U.S.C. §1395ss(z).

The department proposes amendments to 28 TAC §§3.3302 – 3.3308, 3.3312, 3.3316, 3.3317, and 3.3323 – 3.3325, as necessary, to update outdated contact information and administrative and statutory citations. Proposed amendments to these sections are also necessary for consistency with the agency's writing style.

The department proposes amendments to 28 TAC §3.3306(b)(1)(E). These proposed amendments are necessary to permit, under certain circumstances, an issuer to replace a certificate with a certificate of the same standardized benefit plan when an individual moves from this state to a different state. The department also proposes to amend 28 TAC §3.3306 by deleting subsections (c) and (d), concerning benefit standards for 1990 standardized Medicare supplement plan policies and certificates issued for delivery on or after March 1, 1992, and with an effective date for coverage before June 1, 2010. This proposed amendment is necessary because the 1990 standardized Medicare supplement benefit plans are no longer issued.

The department proposes to amend 28 TAC §3.3307(f) by deleting the current refund calculation form and replacing it with a new refund calculation form. This proposed amendment is necessary to require an issuer to electronically submit the reporting form found on the department's website.

The department proposes the repeal of 28 TAC §3.3318, relating to the effective date of amendments and its impact on existing policies. This proposed repeal is necessary because this provision will be included under 28 TAC §3.3302, relating to applicability and scope.

EXPLANATION. The Medicare Access and CHIP Reauthorization Act (MACRA) was enacted on April 16, 2015. Starting on January 1, 2020, it prohibits the sale of Medicare supplement plans that cover Part

B deductibles to a "newly eligible Medicare beneficiary." A "newly eligible Medicare beneficiary" is defined under 42 U.S.C. §1395ss(z)(2) as an individual who: has attained age 65 on or after January 1, 2020; becomes eligible for Medicare due to age, disability, or end-stage renal disease on or after January 1, 2020, by reason of entitlement under 42 U.S.C. §426(b) or 42 U.S.C. §426-1; or who is deemed to be eligible for benefits under 42 U.S.C. §426(a). Plans C, F, and High Deductible F, which include coverage for the Part B deductible, will not be available to a newly eligible individual. NAIC adopted revisions on August 29, 2016, to its NAIC Model Regulation to implement the MACRA requirements concerning Medicare supplement insurance. On September 1, 2017, the Department of Health and Human Services issued a notice in 82 Federal Register 169 recognizing the revised NAIC Model standards for regulation of Medicare supplement insurance for purposes of 42 U.S.C. §1395ss.

If a state's Medicare supplement program does not provide for the application and enforcement of the NAIC Model Standards and requirements in 42 U.S.C. §1395ss(b)(1), no Medicare supplement policy may be issued in that state, unless the policy has been certified by the Secretary of the United States Department of Health and Human Services as meeting minimum standards and requirements under the procedures established in 42 U.S.C. §1395ss(a)(1). Title 42 U.S.C. §1395ss(b)(1) provides that Medicare supplement policies issued in a state are deemed to meet the federal requirements if the state's program regulating Medicare supplement policies provides for the application of standards that are at least as stringent as those contained in the NAIC Model Regulation and if the state's requirements are equal to or more stringent than those in subsection 42 U.S.C. §1395ss(c)(2)-(5).

Insurance Code §1652.005 provides that, in addition to other rules required or authorized by Chapter 1652, the commissioner must adopt reasonable rules necessary and proper to carry out Chapter 1652, including rules adopted in accordance with federal law relating to the regulation of Medicare supplement benefit plan coverage that are necessary for this state to retain certification as a state with an approved regulatory program for Medicare supplement insurance.

Insurance Code §1652.051 provides, in part, that the commissioner must adopt reasonable rules to establish specific standards for provisions in Medicare supplement benefit plans and standards for facilitating comparisons of different Medicare supplement benefit plans. The standards are in addition to and must be in accordance with applicable laws of this state; applicable federal law, rules, regulations, and standards; and any model rules and regulations required by federal law, including 42 U.S.C. §1395ss. The standards may include provisions relating to terms of renewability; benefit limitations, exceptions, and reductions; and exclusions required by state or federal law.

Insurance Code §1652.052(a) provides that the commissioner must adopt reasonable rules to establish minimum standards for benefits and claim payments under Medicare supplement benefit plans. Insurance Code §1652.052(b) states that the standards for benefits and claim payments must include the requirements for certification of Medicare supplement benefit plans under 42 U.S.C. §1395ss. Based on state and federal law, proposed amendments to §§3.3303, 3.3306, 3.3308, and 3.3312 are necessary to retain certification as a state with an approved regulatory program for Medicare supplement insurance.

The department acknowledges that individuals issued a certificate in this state may move for various reasons to a different state and that issuers typically adjust premium rates to reflect costs in a given geographic location. Therefore, proposed amendments to 28 TAC §3.3306(b)(1)(E), concerning group Medicare supplement policies, provide that, if an individual holds a Texas-issued certificate in a group Medicare supplement policy, and the individual moves out of the state in which the certificate was issued, the issuer may replace the certificate with a certificate of the same standardized benefit plan type, approved by the new state of residence, if the issuer acts uniformly in its treatment of certificate holders who move out of state. This change is intended to provide administrative simplification for issuers related to rate filings.

Insurance Code §1652.102(c) provides that the commissioner may adopt rules relating to filing requirements for rates, rating schedules, and loss ratios. The proposed amendments to 28 TAC §3.3307(f), concerning refund or credit calculations, are necessary for both efficiency and consistency in reporting the required data.

A description of changes to specific sections follows.

Section 3.3302. The proposal updates a statutory citation. The proposal also adds subsection (b) derived from current 28 TAC §3.3318, which is proposed for repeal. Placing these provisions in §3.3302 is more consistent with the subject matter of the applicability and scope of Insurance Code Chapter 1652. This proposed new subsection states that policies and certificates delivered or issued for delivery before June 1, 2010, are subject to the laws and rules as they existed at the time the policy was delivered or issued for delivery, and those sections are continued in effect for that purpose.

Section 3.3303. The proposal adds a new definition to §3.3303 for "2020 newly eligible individual" for consistency with how such an individual is defined under MACRA, 42 U.S.C. §1395ss(z)(2), and it renumbers the remaining definitions as appropriate to reflect the addition of the new

definition. The proposal also updates statutory citations in proposed new paragraph (20) to reflect the nonsubstantive recodification of the Insurance Code.

Section 3.3304. The proposal updates administrative code citations in paragraph (11) to be consistent with §3.3306 as proposed.

Section 3.3305. The proposal updates administrative code citations in subsections (a) and (d) to be consistent with §3.3306 as proposed.

Section 3.3306. The proposal conforms §3.3306 to amendments made by MACRA that prohibit the sale of Medicare supplement plans that cover Part B deductibles to a newly eligible Medicare beneficiary.

The proposal adds a new subsection (a) and redesignates the subsections that follow it to reflect this change. The following descriptions address the subsections as redesignated, unless stated otherwise.

Proposed new subsection (a)(1) clarifies that the standards and requirements of subsections (b) and (c) apply to all Medicare supplement policies or certificates delivered or issued for delivery to 2020 newly eligible individuals, with the exception of subsections (b)(3)(C), (c)(5)(C), (c)(5)(E), and (c)(5)(F). The proposal further clarifies that 2020 newly eligible individuals are only eligible to purchase standardized Medicare supplement benefit plans A, B, D, G, High Deductible G, K, L, M, and N. The proposal states that standardized Medicare supplement plans C, F, and High Deductible F may not be offered to 2020 newly eligible individuals.

The proposal further states in subsections (b) and (c) that benefit standards applicable to Medicare supplement policies and certificates issued or issued for delivery with an effective date before June 1, 2010, remain subject to the laws and rules in effect when the policy or certificate was delivered or issued for delivery. The proposal makes a correction to a citation in subsection (b)(1)(E)(iii) by changing "(iv)" to "(v)." This proposed amendment is necessary because the citation is inconsistent with the citation reference in the NAIC Model Rule. The proposal adds new subsection (b)(1)(E)(vi), which provides that if an individual is a Texas certificate holder in a group Medicare supplement policy and the individual moves out of the state where the certificate was issued, the issuer may replace the Texas certificate with a certificate of the same standardized benefit plan type, approved by the new state of residence, if the issuer treats all certificate holders who move out of state uniformly.

The proposal adds the words "G with High Deductible" in subsection (b)(2) and clarifies that (c)(1)(B)(i) applies to any individual who first became eligible for Medicare before January 1, 2020. The proposal adds new subsection (c)(5)(H) to provide the standardized plan requirements for Plan G with

High Deductible. To streamline and simplify the rules, the proposal deletes current subsections (c) and (d), concerning benefit standards for 1990 Standardized Medicare supplement benefit plans, policies, or certificates, and specific references to these plans and pre-standardized Medicare supplement benefit plans. However, as stated in proposed §3.3302(b), these plans remain subject to the laws and rules in effect when the policy or certificate was delivered or issued for delivery. For consistency with the proposed new outline of coverage, the proposal updates deductible and out-of-pocket limit amounts to reflect 2017 coverage levels, as published by CMS. The proposal also updates administrative code citations to reflect the proposed redesignations within the section.

Section 3.3307. The proposal revises §3.3307(f) to state that an issuer must use the online data reporting form found on the department's website concerning calculations to electronically submit the required data no later than May 31st of each year. The proposal also deletes the current Figure: 28 TAC §3.3307(f) and replaces it with a proposed new Figure: 28 TAC §3.3307(f) to improve the clarity of the language and grammar within the form and to add a checkbox that enables an issuer with no data to report to automatically populate zeros in all relevant form fields. The proposal also updates the statutory citation in subsection (g) to reflect the nonsubstantive recodification of the Insurance Code.

Section 3.3308. The proposal deletes §3.3308(c)(2)(F), relating to Outline of Coverage form, relating to policies sold with an effective date for coverage before June 1, 2010, and on or after March 1, 1992, and repeals Form No. LHL 050 Rev. 12/04. The proposal amends subsection (c)(2)(E), concerning the Outline of Coverage form, Form No. LHL 050 Rev. 06/09, applicable to policies with an effective date for coverage of June 2010 or later. The proposal also repeals LHL 050 Rev. 06/09 and creates an updated version of the form titled "LHL 050 Rev. 12/17."

Proposed new LHL 050 Rev. 12/17 includes disclosure provisions that were inadvertently excluded from LHL 050 Rev. 06/09 that address limitations and exclusions, refund of premium, and grievance procedures, which are consistent with subsections (c)(2)(B)-(D). The proposed new form also reflects proposed amendments to §3.3306, by including a new benefit chart of Medicare supplement plans sold on or after January 1, 2020, and by modifying the Plan G summary to reflect the new high deductible option.

The proposal makes nonsubstantive editorial and formatting changes to conform to the agency's current style and to improve the rule's clarity. The proposal also updates an administrative code citation at subsection (a)(4)(C) to reflect §3.3306 as proposed. In order to provide adequate time for issuers to make changes to the outline of coverage and file new forms, consistent with LHL 050 Rev. 12/17,

proposed §3.3308(c)(2)(E) indicates that issuers are not required to begin using the proposed new form until July 1, 2018.

Section 3.3312. The proposal amends §3.3312(c) to clarify the products that 2020 newly eligible individuals are entitled to purchase under the guaranteed issue provisions.

Section 3.3316. The proposal updates a statutory citation to reflect the nonsubstantive recodification of the Insurance Code.

Section 3.3317. The proposal updates a statutory citation to reflect the nonsubstantive recodification of the Insurance Code.

Section 3.3318. The proposal repeals current §3.3318. Proposed amendments to §3.3302(b) incorporate some of the provisions repealed in §3.3318, as previously described.

Section 3.3323. The proposal corrects a citation to include the full name of a section title and updates a statutory citation to reflect the nonsubstantive recodification of the Insurance Code.

Section 3.3324. The proposal deletes outdated language related to enrollment prior to 1997. The proposal also updates an administrative code citation in subsection (d), consistent with proposed §3.3306.

In addition to the proposed changes previously described, the proposal makes nonsubstantive editorial and formatting changes in §§3.3303, 3.3304, 3.3305, 3.3306, 3.3307, 3.3312, 3.3316, 3.3317, 3.3323, 3.3324, and 3.3325.

This proposal includes provisions related to NAIC model rules, regulations, directives, or standards, and, the department must consider whether authority exists to enforce or adopt NAIC model rules, regulations, directives, or standards under Insurance Code §36.004 and §36.007. The department has determined that Insurance Code §36.004 and §36.007 do not prohibit the proposed amendments because Insurance Code §1652.005 provides that, in addition to other rules required or authorized by Chapter 1652, the commissioner must adopt reasonable rules necessary and proper to carry out Chapter 1652. These rules include those adopted in accordance with federal law relating to the regulation of Medicare supplement benefit plan coverage that are necessary for this state to retain certification as a state with an approved regulatory program for Medicare supplement insurance.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Patricia Brewer, team lead for the Life and Health Regulatory Initiatives Team, has determined that for each year of the first five years the proposed amendments and repeal will be in effect, there will be no measureable fiscal impact on state and local governments as a result of the enforcement or administration of this proposal. Ms. Brewer

does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each of the first five years the proposed amendments and repeal are in effect, Ms. Brewer expects that administering and enforcing the proposed amendments and repeal will have the public benefits of: (1) ensuring that the department's rules and outline-of-coverage form comply with Insurance Code §§1652.005, 1652.051, 1652.052, 1652.102, 1652.151, and 1652.152 in order to retain certification as a state with an approved regulatory program for Medicare supplement insurance; (2) adopting a new refund calculation data reporting form that will ease issuers' reporting and submission process; and (3) ensuring that Texas certificate holders who move to a different state retain the same standardized benefit plan type when the issuer satisfies certain requirements concerning certificate holders who move to a different state.

Ms. Brewer expects that the proposed amendments and repeal will not increase the cost of compliance with Insurance Code Chapter 1652 because it does not impose requirements beyond those under state and federal law. Insurance Code §1652.005 provides that, in addition to other rules required or authorized by this chapter, the commissioner must adopt reasonable rules necessary and proper to carry out Chapter 1652, including rules adopted in accordance with federal law relating to the regulation of Medicare supplement benefit plan coverage that are necessary for this state to retain certification as a state with an approved regulatory program for Medicare supplement insurance.

Insurance Code §1652.051 provides, in part, that the commissioner must adopt reasonable rules to establish specific standards for provisions in Medicare supplement benefit plans and standards for facilitating comparisons of different Medicare supplement benefit plans. The standards are in addition to and must be in accordance with applicable laws of this state; applicable federal law, rules, regulations, and standards; and any model rules and regulations required by federal law, including 42 U.S.C. §1395ss. The standards may include provisions relating to terms of renewability; benefit limitations, exceptions, and reductions; and exclusions required by state or federal law.

Insurance Code §1652.052(a) provides that the commissioner must adopt reasonable rules to establish minimum standards for benefits and claim payments under Medicare supplement benefit plans. Insurance Code §1652.052(b) states that the standards for benefits and claim payments must include the requirements for certification of Medicare supplement benefit plans under 42 U.S.C. §1395ss.

Insurance Code §1652.151 provides, in part, that the rules adopted under §1652.152 must include provisions and requirements that are at least equal to those required by federal law, including the rules, regulations, and standards adopted under 42 U.S.C. §1395ss.

Issuers are permitted, but not required, to replace a certificate issued in Texas with a certificate of the same standardized plan type approved in a certificate holder's new state of residence. Any associated cost is attributable to the issuer's decision to replace the certificate and does not result from the enforcement or administration of the proposed new subsection.

Insurance Code §1652.152(b) provides that the commissioner by rule must prescribe the format and content of the outline of coverage required by subsection (a). The rules must address the style, arrangement, and overall appearance of the outline of coverage, including the size, color, and prominence of type and the arrangement of text and captions.

Issuers must update outline-of-coverage forms to comply with the proposed new LHL 050 Rev. 12/17 form and file the form with the department for review. The costs associated with implementation are the result of the enactment of MACRA and the requirements under Insurance Code Chapter 1652 for the commissioner to adopt reasonable rules necessary and proper to carry out Chapter 1652. This includes model rules adopted under federal law relating to the regulation of Medicare supplement benefit plan coverage and that are necessary for this state to retain certification as a state with an approved regulatory program for Medicare supplement insurance. Therefore, the costs associated with changing the outline-of-coverage form do not result from the enforcement or administration of the proposed amendments and repeal.

The department estimates that there are no measurable additional costs in the submission of the electronic refund calculation reporting form over the internet. Insurance Code §1652.102(c) provides that the commissioner may adopt rules relating to filing requirements for rates, rating schedules, and loss ratios. The proposed amendment to require electronic submission of the refund calculation reporting form will benefit both the issuers reporting and the department. Issuers will not have to print and scan the reports to submit them to the department. The department will not have to print the reports to manually enter the information into the database, which is time consuming and can lead to data entry errors. Because of the integrated error checking, the department will spend less time corresponding with issuers about data errors.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. The department has determined that the proposed amendments and repeal will not have an adverse economic effect or a disproportionate impact on small or micro businesses or on rural communities. Any costs are the result of implementation of federal and state law requirements, which do not permit lowered requirements for small businesses. Additionally, the proposal permits, but does not require, issuers to replace a Texas certificate with a certificate of the same standardized benefit plan type, approved by the new state of residence, when an individual who is a certificate holder in a group Medicare supplement policy moves out of the state. The proposed new refund calculation data reporting form requires electronic submission, which will ease the reporting and submission process and should result in no measurable costs to issuers. As a result, and in accordance with Government Code §2006.002(c), the department is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. The department has determined that the proposed amendments are required by and are consistent with federal law (MACRA) and Insurance Code Chapter 1652 and do not impose requirements on any individual or entity other than those imposed under federal and state laws. Any costs to such persons result from the federal enactment of MACRA and Insurance Code Chapter 1652 and are not the result of the adoption, enforcement, or administration of the proposed amendments and repeal. In addition, Government Code §2001.0045 does not apply to this proposal because it is necessary to implement MACRA under Insurance Code §§1652.005, 1652.051, 1652.052, 1652.151, 1652.152, and 42 U.S.C. §1395ss to ensure that Texas retains certification as a state with an approved regulatory program for Medicare supplement insurance.

TAKINGS IMPACT ASSESSMENT. The department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action, and so does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. Submit any written comments on the proposal no later than 5 p.m., Central time, on January 22, 2018, by mail to the Office of the Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104; or by email to chiefclerk@tdi.texas.gov. Simultaneously submit an additional copy of the comments to Patricia Brewer,

Regulatory Initiatives Team, Life and Health Lines Office, Mail Code 106-1D, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104; or by email to lhlcomments@tdi.texas.gov. Separately submit any request for a public hearing to the Texas Department of Insurance, Office of the Chief Clerk, Mail Code 113-2A, P.O. Box 149104, Austin, Texas 78714-9104, or by email to chiefclerk@tdi.texas.gov, before the close of the public comment period. If the department holds a hearing, the commissioner will consider written and oral comments presented at the hearing.

STATUTORY AUTHORITY. The amended sections are proposed under Insurance Code §§1652.005, 1652.051, 1652.052, 1652.102, 1652.151, 1652.152, and 36.001; and 42 U.S.C. §1395ss.

Insurance Code §1652.005 provides that, in addition to other rules required or authorized by this chapter, the commissioner must adopt reasonable rules necessary and proper to carry out Chapter 1652, including rules adopted in accordance with federal law relating to the regulation of Medicare supplement benefit plan coverage that are necessary for this state to obtain or retain certification as a state with an approved regulatory program.

Insurance Code §1652.051 provides, in part, that the commissioner must adopt reasonable rules to establish specific standards for provisions in Medicare supplement benefit plans and standards for facilitating comparisons of different Medicare supplement benefit plans. The standards are in addition to and must be in accordance with applicable laws of this state; applicable federal law, rules, regulations, and standards; and any model rules and regulations required by federal law, including 42 U.S.C. §1395ss. The standards may include provisions relating to terms of renewability; benefit limitations, exceptions, and reductions; and exclusions required by state or federal law.

Insurance Code §1652.052(a) provides that the commissioner must adopt reasonable rules to establish minimum standards for benefits and claim payments under Medicare supplement benefit plans. Insurance Code §1652.052(b) states that the standards for benefits and claim payments must include the requirements for certification of Medicare supplement benefit plans under 42 U.S.C. §1395ss.

Insurance Code §1652.102(c) provides that the commissioner may adopt rules relating to filing requirements for rates, rating schedules, and loss ratios.

Insurance Code §1652.151 provides, in part, that the rules adopted under §1652.152 must include provisions and requirements that are at least equal to those required by federal law, including the rules, regulations, and standards adopted under 42 U.S.C. §1395ss.

Insurance Code §1652.152(a) provides that for full and fair disclosure in the sale of Medicare supplement benefit plans, a Medicare supplement benefit plan or certificate may not be delivered or issued for delivery in Texas unless an outline of coverage that complies with §1652.152 is delivered to the applicant when the applicant applies for the coverage, and Insurance Code §1652.152(b) provides that the commissioner by rule must prescribe the format and content of the outline of coverage required by §1652.152(a). The rules must address the style, arrangement, and overall appearance of the outline of coverage, including the size, color, and prominence of type and the arrangement of text and captions.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of Texas.

Title 42 U.S.C. §1395ss(a)(2)(A) provides, in part, that no Medicare supplemental policy may be issued in a state on or after the date specified, unless the state's regulatory program provides for the application and enforcement of the NAIC Model Standards and requirements.

CROSS REFERENCE TO STATUTE. Amendments to 28 TAC §§3.3302 – 3.3308, 3.3312, 3.3316, 3.3317, and 3.3323 – 3.3325 affect Insurance Code §§1652.005, 1652.051, 1652.052, 1652.102, 1652.151, 1652.152, and 36.001; and 42 U.S.C. §1395ss.

TEXT.

§3.3302. Applicability and Scope.

(a) Except as otherwise specifically provided, this subchapter applies to:

(1) all Medicare supplement policies as defined in [~~the~~] Insurance Code §1652.002 [~~, Article 3.74, §1(b)(3),~~] and §3.3303 of this title (relating to Definitions) delivered or issued for delivery in this state on or after the effective date of this subchapter; and

(2) all certificates issued under group Medicare supplement policies, for which certificates have been delivered or issued for delivery in this state regardless of the place where the policy was delivered or issued for delivery. In this subchapter, the required minimum standards for Medicare supplement insurance, which make specific reference to a policy or policies, are equally applicable to a group certificate or certificates.

(b) Policies and certificates delivered or issued for delivery before June 1, 2010, are subject to the laws and rules as they existed at the time the policy was delivered or issued for delivery and those sections or portions of sections are continued in effect for that purpose.

§3.3303. Definitions.

The following words and terms, when used in this subchapter, [~~shall~~] have the following meanings, unless the context clearly indicates otherwise.

(1) 1990 Standardized Medicare supplement benefit plan, 1990 Standardized benefit plan, or 1990 plan--A group or individual policy of Medicare supplement insurance issued or issued for delivery on or after March 1, 1992, and with an effective date for coverage before [~~prior to~~] June 1, 2010.

(2) 2010 Standardized Medicare supplement benefit plans, 2010 Standardized benefit plan, or 2010 plan--A group or individual policy of Medicare supplement insurance with an effective date for coverage on or after June 1, 2010.

(3) 2020 newly eligible individual--An individual who is newly eligible for Medicare on or after January 1, 2020:

(A) by reason of attaining age 65 on or after January 1, 2020; or

(B) by reason of entitlement to benefits under Part A under section 42 U.S.C. §426(b) or 42 U.S.C. §426-1, or who is deemed to be eligible for benefits under section 42 U.S.C. §426(a) on or after January 1, 2020. An individual who becomes Medicare eligible or turns 65 before January 1, 2020, is not a 2020 newly eligible individual.

(4) [~~(3)~~] Applicant--

(A) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance or other health benefits.

(B) In the case of a group Medicare supplement policy, the proposed certificate holder.

(5) [~~(4)~~] Bankruptcy--The situation that occurs when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in Texas [~~this state~~].

(6) [~~(5)~~] Certificate--Any certificate issued under a group Medicare supplement policy, for which a certificate has been delivered or issued for delivery in this state regardless of the place where the policy was delivered or issued for delivery.

(7) [~~(6)~~] Continuous period of creditable coverage--The period during which an individual was covered by creditable coverage, if, during the period of the coverage, the individual had no breaks in coverage greater than 63 days.

(8) [~~(7)~~] Creditable coverage--Any coverage of an individual as defined in §21.1101 of this title (relating to Definitions).

(9) [~~(8)~~] Employee welfare benefit plan--A plan, fund, or program of employee benefits as defined in 29 U.S.C. §1002[~~Section 1002~~] (Employee Retirement Income Security Act).

(10) [~~(9)~~] Health Maintenance Organization (HMO)--An entity as defined in 42 U.S.C. §300e(a).

(11) [~~(10)~~] Insolvency--The situation that [~~which~~] occurs when an issuer has had an order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

(12) [~~(11)~~] Issuer--An insurance company, fraternal benefit society, health care service plan, health maintenance organization, or any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

(13) [~~(12)~~] Medicaid--Grants to States for Medical Assistance Programs, Title XIX of the Social Security Act Amendments of 1965 as then constituted or later amended [~~Then Constituted or Later Amended~~].

(14) [~~(13)~~] Medicare--The Health Insurance for the Aged Act, Title XVIII of the Social Security Act Amendments of 1965 as then constituted or later amended [~~Then Constituted or Later Amended~~].

(15) [~~(14)~~] Medicare Advantage organization--An entity as defined in 42 U.S.C. §1395w-28(a)(1).

(16) [~~(15)~~] Medicare Advantage plan--A plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. §1395w-28(b)(1), and includes:

(A) coordinated care plans that [~~which~~] provide health services, including but not limited to HMO [~~health maintenance organization~~] plans (with or without a point of service [~~point-of-service~~] option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

(B) medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and

(C) Medicare Advantage private fee-for-service plans.

(17) [~~(16)~~] Medicare Advantage private fee-for-service plan--An entity as defined in 42 U.S.C. §1395w-28(b)(2).

(18) [~~(17)~~] MMA--The Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(19) [~~(18)~~] Medicare Select policy or Medicare Select certificate--A Medicare supplement policy or certificate, respectively, that contains restricted network provisions.

(20) [~~(19)~~] Medicare supplement policy--A group or individual policy of accident and sickness insurance or a subscriber contract of a group hospital service corporation subject to [~~the~~] Insurance Code[~~,~~] Chapter 842 (concerning Group Hospital Service Corporations) [~~20~~], or, to the extent required by federal law, an evidence of coverage issued by an HMO [~~a health maintenance organization~~] subject to [~~the~~] Insurance Code Chapter 843 (concerning Health Maintenance Organizations) [~~Texas Health Maintenance Organization Act~~], for which a policy, subscriber contract, or [~~such~~] evidence of coverage is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. The term does not include:

(A) a policy, contract, subscriber contract, or evidence of coverage of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations;

(B) a policy or health care benefit plan including a policy or contract of group insurance or group contract of a group hospital service corporation subject to [~~the~~] Insurance Code[~~,~~] Chapter 842 [~~20~~], or group evidence of coverage issued by an HMO [~~a health maintenance organization~~] subject to [~~the~~] Insurance Code Chapter 843 [~~Health Maintenance Organization Act~~], when such policy or plan is not marketed or held to be a Medicare supplement policy or benefit plan; or

(C) an individual or group evidence of coverage issued under [~~pursuant to~~] a contract in accordance with [~~under~~] the Federal Social Security Act, §1876 (42 U.S.C. §§1395, et seq.) by an HMO [~~a health maintenance organization~~] subject to Insurance Code Chapter 843 [~~the Texas Health Maintenance Organization Act (Texas Insurance Code, Chapters 20A and 843)~~];

(D) a Medicare Advantage plan established under Medicare Part C;

(E) an Outpatient Prescription Drug plan established under Medicare Part D; or

(F) a Health Care Prepayment Plan (HCPP) that provides benefits under [~~pursuant to~~] an agreement under §1833(a)(1)(A) of the Federal Social Security Act (42 U.S.C. §§1395, et seq.)

(21) [~~(20)~~] Point of service [~~Point-of-service~~]--A benefit option as defined in 42 C.F.R. §422.2.

(22) [~~(21)~~] Pre-Standardized Medicare supplement benefit plan, Pre-Standardized benefit plan or Pre-Standardized plan--A group or individual policy of Medicare supplement insurance issued or issued for delivery before [~~prior to~~] March 1, 1992.

(23) [~~(22)~~] Provider-sponsored [~~Sponsored~~] organization--An entity as defined in 42 U.S.C. §1395w-25(d)(1).

(24) [~~(23)~~] Qualified actuary--An actuary who is a member of either the Society of Actuaries or the American Academy of Actuaries.

(25) [~~(24)~~] Secretary--The Secretary of the United States Department of Health and Human Services.

§3.3304. Policy Definitions and Terms.

No insurance policy, subscriber contract, certificate, or evidence of coverage may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy unless the [~~such~~] policy, subscriber contract, certificate, or evidence of coverage contains definitions or terms that [~~which~~] conform to the requirements of this section.

(1) "Accident[~~,~~]" or "Accidental Injury[~~,~~]" or "Accidental Means" must [~~shall~~] be defined to employ "result" language and may [~~shall~~] not include words that [~~which~~] establish an accidental means test or use words such as "external, violent, visible wounds," or similar words of description or characterization.

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

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

(2) "Benefit Period" or "Medicare Benefit Period" may not be defined as more restrictive than as that defined in the Medicare program.

(3) "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" may [~~shall~~] not be defined more restrictively than as defined in the Medicare program.

(4) "Health Care Expenses" are, for purposes of §3.3307 of this title [~~chapter~~] (relating to Loss Ratio Standards and Refund or Credit of Premiums), those expenses of health maintenance organizations associated with the delivery of health care services and analogous to incurred losses of insurers.

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

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

(7) "Medicare-Approved [~~Medicare Approved~~] Amounts" refer to the level of service or amount of health care reimbursement recognized and approved for a particular medical or health care service or procedure by Medicare.

(8) "Medicare-Eligible [~~Medicare Eligible~~] Expenses" are health care expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

(9) "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN). If the words "nurse," "trained nurse," or "registered nurse" are used without specific instruction, then the use of the [~~such~~] terms requires the issuer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the Texas Board of Nursing [~~licensing or registry board of Texas~~].

(10) "Physician" may [~~shall~~] not be defined more restrictively than as defined in the Medicare program. An issuer must recognize and accept, to the extent of its obligation under the contract,

all providers of medical care and treatment, when such services are within the scope of the provider's licensed authority and are provided under [~~pursuant to~~] applicable laws.

(11) "Sickness" may [~~shall~~] not be defined to be more restrictive than the following: "Sickness means illness or disease of a covered person that [~~which~~] first manifests itself after the effective date of insurance or health coverage and while the insurance or health coverage is in force." The definition may [~~shall~~] not be construed to limit §3.3306(b)(1) of this title (relating to Minimum Benefit Standards). The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law.

§3.3305. Policy Provisions.

(a) Except for permitted preexisting [~~pre-existing~~] condition clauses described in §3.3306(b)(1)(A) of this title (relating to Minimum Benefit Standards), no policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

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

(c) No Medicare supplement policy, contract, or certificate in force in this state may [~~shall~~] contain benefits that [~~which~~] duplicate benefits provided by Medicare.

(d) Subject to §3.3306(b)(1)(D) and (E) of this title, a Medicare supplement policy with benefits for outpatient prescription drugs in existence before [~~prior to~~] January 1, 2006, must [~~shall~~] be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

(e) A Medicare supplement policy with benefits for outpatient prescription drugs may [~~shall~~] not be issued after December 31, 2005.

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

(1) the policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan; and

(2) premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

§3.3306. Minimum Benefit Standards.

(a) Benefit standards for standardized Medicare supplement benefit plan policies or certificates issued to 2020 newly eligible individuals. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provides that no policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. Benefit standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of subsections (b) and (c) of this section. All policies issued to a 2020 newly eligible individual, as defined in this subchapter, must comply with the following benefit standards:

(1) Benefit requirements. The standards and requirements of subsections (b) and (c) of this section apply to all Medicare supplement policies or certificates delivered or issued for delivery to 2020 newly eligible individuals, with the exception of subsections (b)(3)(C), (c)(5)(C), (c)(5)(E), and (c)(5)(F) of this section.

(2) Eligibility to purchase. A 2020 newly eligible individual is only eligible to purchase standardized Medicare supplement benefit plans A, B, D, G, High Deductible G, K, L, M, and N. Standardized Medicare supplement benefit plans C, F, and High Deductible F may not be offered to 2020 newly eligible individuals.

(b) [~~(a)~~] Benefit standards for 2010 standardized Medicare supplement benefit plan policies or certificates issued or issued for delivery with an effective date for coverage on or after [~~Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued or Issued for Delivery with an Effective Date for Coverage on or After~~] June 1, 2010. This section specifies the minimum standards applicable to all Medicare supplement policies or certificates issued or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No insurance policy, subscriber contract, certificate, or evidence of coverage may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy unless the policy, contract, certificate, or evidence of coverage meets the applicable standards in paragraphs (1) - (3) of this subsection [~~section~~]. No issuer may offer or issue any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued or issued for delivery with an effective date before [~~prior to~~] June 1, 2010, remain subject to the laws and rules in effect when the policy or certificate was delivered or issued for delivery [~~requirements of subsections (c) and (d) of this~~

~~section~~]. These are minimum standards and do not prevent [~~preclude~~] the inclusion of other provisions or benefits that [~~which~~] are not inconsistent with these standards.

(1) General standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this subchapter, [~~the~~] Insurance Code Chapter 1652, and any other applicable law.

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

(i) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer must [~~shall~~] waive any time [~~periods~~] applicable to preexisting condition waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy or certificate to the extent the [~~such~~] time was spent under the original policy.

(ii) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy or certificate must [~~shall~~] not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods for benefits.

(iii) If a Medicare supplement policy or certificate is issued or issued for delivery to an applicant who qualifies under §3.3312(b) of this title [~~subchapter~~] (relating to Guaranteed Issue for Eligible Persons) or §3.3324(a) of this title [~~subchapter~~] (relating to Open Enrollment), the issuer must [~~shall~~] reduce the period of any preexisting condition exclusion as required by §3.3312(a)(2) of this subchapter and §3.3324(c) and (d) of this title [~~subchapter~~].

(B) A Medicare supplement policy or certificate may [~~shall~~] not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

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

(D) A [~~No~~] Medicare supplement policy or certificate may not [~~shall~~]:

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

(ii) be canceled [~~cancelled~~] or nonrenewed by the insurer solely on the grounds of deterioration of health.

(E) Each Medicare supplement policy must [~~shall~~] be guaranteed renewable and must [~~shall~~] comply with the provisions of clauses (i) - (vi) [~~(v)~~] of this subparagraph.

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

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

(iii) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided in clause (v) [~~(iv)~~] of this subparagraph, the issuer must [~~shall~~] offer certificate holders an individual Medicare supplement policy that [~~which~~], at the option of the certificate holder:

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

(II) provides for benefits that otherwise meet the requirements of this subparagraph.

(iv) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer must [~~shall~~]:

(I) offer the certificate holder the conversion opportunity described in clause (iii) of this subparagraph; or

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

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

(vi) If an individual is issued a certificate in Texas in a group Medicare supplement policy and the individual moves out of the state, the issuer may replace the Texas certificate with a certificate of the same standardized benefit plan type, approved by the new state of residence, if the issuer acts uniformly in its treatment of certificate holders who move out of Texas.

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

(G) A Medicare supplement policy or certificate must [~~shall~~] comply with clauses (i) - (iv) of this subparagraph:

(i) A Medicare supplement policy or certificate must [~~shall~~] provide that benefits and premiums under the policy or certificate will [~~shall~~] be suspended at the request of the policyholder or certificate holder for the period, not to exceed 24 months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to that assistance.

(ii) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate must [~~shall~~] be automatically reinstituted effective as of the date of termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(iii) Each Medicare supplement policy must [~~shall~~] provide that benefits and premiums under the policy will [~~shall~~] be suspended (for any period that may be provided by federal regulation) at the request of the policyholder or certificate holder if the policyholder or certificate holder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy must [~~shall~~] be automatically reinstituted, effective as of the date of loss of coverage, if the policyholder or certificate holder provides notice of loss of coverage within 90 days after the date of the loss.

(iv) Reinstitution of coverages must [~~shall~~] comply with subclauses (I) - (III) of this clause.

(I) Reinstitution of coverage must [~~shall~~] not provide for any waiting period with respect to treatment of preexisting conditions.

(II) Reinstitution of coverage must [~~shall~~] provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension.

(III) Reinstitution of coverage must [~~shall~~] provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(2) Standards for basic (core) benefits common [~~Basic (Core) Benefits Common~~] to Medicare supplement insurance benefit plans [~~Supplement Insurance Benefit Plans~~] A, B, C, D, F, F with High Deductible, G, G with High Deductible, M, and N. Every issuer of Medicare supplement insurance benefit plans must [~~shall~~] make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not instead [~~in lieu~~] of it. These plans include:

(A) 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;

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

(C) on [~~upon~~] exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must [~~shall~~] accept the issuer's payment as payment in full and may not bill the insured for any balance;

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

(E) coverage for the coinsurance amount[~~,~~] or, in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount[~~,~~] of Medicare

eligible expenses under Part B, regardless of hospital confinement, subject to the Medicare Part B deductible;

(F) coverage of cost sharing for all Part A Medicare-eligible [~~Medicare-eligible~~] hospice care and respite care expenses.

(3) Standards for additional benefits [~~Additional Benefits~~]. The following additional benefits must [~~shall~~] be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, G with High Deductible, M, and N as provided by subsection (c) [~~(b)~~] of this section.

(A) Medicare Part A Deductible:

(i) coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period; or

(ii) coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period.

(B) Skilled nursing facility care [~~Nursing Facility Care~~]: coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(C) Medicare Part B deductible [~~Deductible~~]: coverage for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(D) One hundred percent [~~Hundred Percent~~] of the Medicare Part B excess charges [~~Excess Charges~~]: coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(E) Medically necessary emergency care in a foreign country [~~Necessary Emergency Care in a Foreign Country~~]: 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, which [~~care~~] would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each 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 [~~shall mean~~] care needed immediately because of an injury or an illness of sudden and unexpected onset.

(c)[~~(b)~~] Standard Medicare supplement benefit plans for 2010 standardized Medicare supplement benefit plan policies or certificates issued or issued for delivery with an effective date for coverage on or

after [~~Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued or Issued for Delivery with an Effective Date for Coverage on or After~~] June 1, 2010. The following standards are applicable to all Medicare supplement policies or certificates issued or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No insurance policy, subscriber contract, certificate, or evidence of coverage may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy unless the policy, contract, certificate, or evidence of coverage complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued or issued for delivery with an effective date for coverage before June 1, 2010, remain subject to the laws and rules in effect when the policy or certificate was delivered, or issued for delivery [~~requirements of subsections (c) and (d) of this section~~].

(1) An issuer of a Medicare supplement policy or certificate must [~~shall~~] comply with subparagraphs (A) and (B) of this paragraph:

(A) An issuer must [~~shall~~] make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in subsection (b)[~~(a)~~](2) of this section.

(B) If an issuer makes available any of the additional benefits described in subsection (b)[~~(a)~~](3) of this section, or offers standardized benefit Plans K or L (as described in paragraph (5)(I)[~~(H)~~] and (J)[~~(I)~~] of this subsection), then the issuer must [~~shall~~] make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in subparagraph (A) of this paragraph, a policy form or certificate form containing either:

(i) standardized benefit Plan C (as described in paragraph (5)(C) of this subsection); or

(ii) standardized benefit Plan F (as described in paragraph (5)(E) of this subsection), for any individual who first became eligible for Medicare before January 1, 2020.

(2) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this subsection may [~~shall~~] be offered for sale in this state, except as may be permitted in paragraph (6) of this subsection and in §3.3325 of this title [~~subchapter~~] (relating to Medicare Select Policies, Certificates, and Plans of Operation).

(3) Benefit plans must [~~shall~~] be uniform in structure, language, and format, as well as designation, to the standard benefit plans listed in this paragraph and conform to the definitions in §3.3303

of this title [~~subchapter~~] (relating to Definitions). Each benefit plan must [~~shall~~] be structured in accordance with the format provided in subsection (b)[~~(a)~~](2) and (b)(3) of this section[~~;~~] or, in the case of Plans K or L, in accordance with the format provided in paragraph (5)(I)[~~(H)~~] or (J)[~~(I)~~] of this subsection, [~~;~~] and list the benefits in the order shown. For purposes of this subsection, "structure, language, and format" means style, arrangement, and overall content of a benefit.

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

(5) The make-up of 2010 Standardized Benefit Plans is as specified in subparagraphs (A) – (L) [(~~K~~)] of this paragraph.

(A) Standardized Medicare supplement benefit Plan A must [~~shall~~] include only the following: The basic (core) benefits as defined in subsection (b)[~~(a)~~](2) of this section.

(B) Standardized Medicare supplement benefit Plan B must [~~shall~~] include only the following: The basic (core) benefits as defined in subsection (b)[~~(a)~~](2) of this section, plus 100 percent of the Medicare Part A deductible as defined in subsection (b)[~~(a)~~](3)(A)(i) of this section.

(C) Standardized Medicare supplement benefit Plan C must [~~shall~~] include only the following: The basic (core) benefits as defined in subsection (b)[~~(a)~~](2) of this section, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in subsection (b)[~~(a)~~](3)(A)(i), (B), (C), and (E) of this section, respectively.

(D) Standardized Medicare supplement benefit Plan D must [~~shall~~] include only [~~the following~~]: The basic (core) benefits (as defined in subsection (b)[~~(a)~~](2) of this section), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a[~~n~~] foreign country as defined in subsection (b)[~~(a)~~](3)(A)(i), (B), and (E) of this section, respectively.

(E) Standardized Medicare supplement (regular) Plan F must [~~shall~~] include only the following: The basic (core) benefits as defined in subsection (b) [~~(a)~~](2) of this section, plus 100 percent of the Medicare Part A deductible, the skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in subsection (b)[~~(a)~~](3)(A)(i), (B), (C), (D), and (E) of this section, respectively.

(F) Standardized Medicare supplement Plan F with [~~With~~] High Deductible must [~~shall~~] include 100 percent of covered expenses following the payment of the annual deductible set forth in clause (ii) of this subparagraph.

(i) The basic (core) benefits as defined in subsection (b)[~~(a)~~](2) of this section, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in subsection (b)[~~(a)~~](3)(A)(i), (B), (C), (D), and (E) of this section, respectively.

(ii) The annual deductible in Plan F with [~~With~~] High Deductible must [~~shall~~] consist of out-of-pocket expenses, other than premiums, for services covered by regular Plan F, and must [~~shall~~] be in addition to any other specific benefit deductibles. The basis for the deductible is $2,200 for 2017, and will [~~shall be $1,500 and shall~~] be adjusted annually by the Secretary [~~of the U.S. Department of Health and Human Services~~] to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(G) Standardized Medicare supplement benefit Plan G must [~~shall~~] include only the following: The basic (core) benefits as defined in subsection (b)[~~(a)~~](2) of this section, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in subsection (b)[~~(a)~~](3)(A)(i), (B), (D), and (E), respectively. Effective January 1, 2020, Plan G with a High Deductible, as described in subsection (c)(5)(H), may be offered to any individual who is eligible for Medicare before January 1, 2020.

(H) Standardized Medicare supplement Plan G with High Deductible must include 100 percent of the covered expenses following the payment of the annual deductible set forth in clause (ii) of this subparagraph.

(i) The basic (core) benefits as defined in subsection (b)(2) of this section, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in subsection (b)(3)(A)(i), (B), (D), and (E), respectively.

(ii) The annual deductible in Plan G with High Deductible must consist of out-of-pocket expenses, other than premiums, for services covered by regular Plan G, and must be in

addition to any other specific benefit deductibles. The basis for the deductible is $2,200 for 2017, and will be adjusted annually by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(I)[~~(H)~~] Standardized Medicare supplement Plan K [~~is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and~~] must [~~shall~~] include only the following:

(i) Part A hospital coinsurance [~~Hospital Coinsurance~~], 61st through 90th days: Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(ii) Part A hospital coinsurance [~~Hospital Coinsurance~~], 91st through 150th days: Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(iii) Part A hospitalization after [~~Hospitalization After~~] 150 days [~~Days~~]: On [~~Upon~~] exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable PPS [~~prospective payment system (PPS)~~] rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must [~~shall~~] accept the issuer's payment as payment in full and may not bill the insured for any balance;

(iv) Medicare Part A deductible [~~Deductible~~]: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in clause (x) of this subparagraph;

(v) Skilled nursing facility care [~~Nursing Facility Care~~]: Coverage for 50 percent of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for posthospital [~~post-hospital~~] skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in clause (x) of this subparagraph;

(vi) Hospice care [~~Care~~]: Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in clause (x) of this subparagraph;

(vii) Blood: Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as

defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in clause (x) of this subparagraph;

(viii) Part B cost sharing [~~Cost Sharing~~]: Except for coverage provided in clause (ix) of this subparagraph, coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in clause (x) of this subparagraph;

(ix) Part B preventive services [~~Preventive Services~~]: Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(x) Cost sharing after out-of-pocket limits [~~Sharing After Out-of-Pocket Limits~~]: Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $5,120 in 2017 [~~$4000 in 2006~~], indexed each year by the appropriate inflation adjustment specified by the Secretary [~~of the U.S. Department of Health and Human Services~~].

(J)[~~(I)~~] Standardized Medicare supplement Plan L [~~is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and~~] must [~~shall~~] include only the following:

(i) the benefits described in subparagraph (I)[~~(H)~~](i), (ii), (iii), and (ix) of this paragraph;

(ii) the benefit described in subparagraph (I)[~~(H)~~](iv), (v), (vi), (vii), and (viii) of this paragraph, but substituting 75 percent for 50 percent; and

(iii) the benefit described in subparagraph (I)[~~(H)~~](x) of this subsection, but substituting $2,560 for $5,120 [~~$2000 for $4000~~].

(K)[~~(J)~~] Standardized Medicare supplement Plan M must [~~shall~~] include only the following: The basic (core) benefit as defined in subsection (b)[~~(a)~~](2) of this section, plus 50 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in subsection (b)[~~(a)~~](3)(A)(ii), (B), and (E) of this section, respectively.

(L)[~~(K)~~] Standardized Medicare supplement Plan N must [~~shall~~] include only the following: The basic (core) benefit as defined in subsection (b)[~~(a)~~](2) of this section, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in

a foreign country as defined in subsection (b)[~~(a)~~](3)(A)(i), (B), and (E) of this section, respectively, with copayments in the following amounts:

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

(ii) the lesser of $50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment must [~~shall~~] be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(6) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may [~~shall~~] include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost effective [~~cost-effective~~]. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits may [~~shall~~] not include an outpatient prescription drug benefit. New or innovative benefits may [~~shall~~] not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

[~~(c) Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued or Issued for Delivery on or After March 1, 1992, and with an Effective Date for Coverage Prior to June 1, 2010. No insurance policy, subscriber contract, certificate, or evidence of coverage may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy unless the policy, contract, certificate, or evidence of coverage meets the applicable standards in paragraphs (1) - (3) of this subsection. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.~~]

[~~(1) General standards. The following standards apply to Medicare supplement policies and are in addition to all other requirements of this subchapter, the Insurance Code Chapter 1652, and any other applicable law.~~]

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

[~~(i) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting condition waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.~~]

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

[~~(iii) If a Medicare supplement policy or certificate is issued or issued for delivery to an applicant who qualifies under §3.3312(b) of this subchapter or §3.3324(a) of this subchapter, the issuer shall reduce the period of any preexisting condition exclusion as required by §3.3312(a)(2) of this subchapter and §3.3324(c) and (d) of this subchapter.~~]

[~~(B) A Medicare supplement policy may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.~~]

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

[~~(D) No Medicare supplement policy shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium, or be cancelled or nonrenewed by the insurer solely on the grounds of deterioration of health.~~]

[~~(E) Each Medicare supplement policy shall be guaranteed renewable and shall comply with the provisions of clauses (i) - (v) of this subparagraph.~~]

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

[~~(ii) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided in clause (iv) of this subparagraph, the issuer shall offer certificate holders Medicare supplement coverage which provides benefits as set out in subclause (I) or (II) of this clause, as follow:~~]

[~~(I) an individual Medicare supplement policy which (at the option of the certificate holder):~~]

[~~(-a-) provides for continuation of the benefits contained in the group policy; or~~]

[~~(-b-) provides for benefits that otherwise meet the requirement of this paragraph; or~~]

[~~(II) continuation of benefits under the group plan until there are no longer any certificate holders remaining who have opted for continuation of benefits under the group policy terminated by the policyholder.~~]

[~~(iii) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:~~]

[~~(I) offer the certificate holder conversion opportunity described in clause (ii) of this subparagraph; or~~]

[~~(II) at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.~~]

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

[~~(v) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the MMA, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.~~]

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

[~~(G) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed 24 months) in which the policyholder or certificate holder has applied~~

~~for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance.~~]

~~(i) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.~~

[~~(ii) Each Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended (for any period that may be provided by federal regulation)~~ ~~at the request of the policyholder or certificate holder if the policyholder or certificate holder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy or certificate shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder or certificate holder provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.~~]

[~~(iii) Reinstitution of such coverages shall provide for the following:~~]

[~~(I) waiver of any waiting period with respect to treatment of preexisting conditions;~~]

[~~(II) resumption of coverage which is substantially equivalent to coverage in effect before the date of such suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of the suspension; and~~]

[~~(III) classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.~~]

[~~(H) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the MMA, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.~~]

[~~(2) Standards for the basic (core) benefits common to benefit plans A - J. Every issuer shall make available a policy or certificate including only the basic "core" package of benefits described in subparagraphs (A) - (E) of this paragraph to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu of it. The basic core benefits shall consist of the following:~~]

[~~(A) coverage for 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;~~]

[~~(B) coverage for Part A Medicare eligible expenses, to the extent not covered by Medicare, incurred as daily hospital charges during use of Medicare lifetime hospital inpatient reserve days;~~]

[~~(C) upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;~~]

[~~(D) 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 regulation) unless replaced in accordance with federal regulation; and~~]

[~~(E) coverage for the coinsurance amount (or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount) of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.~~]

[~~(3) Standards for Additional Benefits. The additional benefits as uniformly defined in subparagraphs (A) - (J) of this paragraph and in subsection (d)(2)(O) of this section shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided in subsection (d)(2)(A) - (I) of this section.~~]

[~~(A) Medicare Part A Deductible - Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.~~]

[~~(B) Skilled Nursing Facility Care--Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.~~]

[~~(C) Medicare Part B Deductible--Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.~~]

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

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

[~~(F) Basic Outpatient Prescription Drug Benefit--Coverage for 50% 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. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.]

[~~(G) Extended Outpatient Prescription Drug Benefit--Coverage for 50% 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. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.~~]

[~~(H) Medically Necessary Emergency Care in a Foreign Country--Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each 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" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.~~]

[~~(I) Preventive Medical Care Benefit or Services--Coverage for the preventive health services described in clauses (i) and (ii) of this subparagraph. Coverage for preventive medical care benefits or services shall be for the actual charges up to 100% of the Medicare-approved amount for each~~

service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare:]

[(i) an annual clinical preventive medical history and physical examination that may include tests and services from clause (ii) of this subparagraph and patient education to address preventive health care measures;]

[(ii) preventive screening tests or preventive services, the selection and frequency of which are determined to be medically appropriate by the attending physician.]

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

[(i) For purposes of this benefit, the following definitions in subclauses (I) - (IV) of this clause shall apply.]

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

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

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

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

[(ii) Coverage requirements and limitations.]

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

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

(III) Coverage is limited to:]

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

[~~(-b-) the actual charges for each visit up to maximum coverage of $40 per visit;~~]

[~~(-c-) $1,600 per calendar year;~~]

[~~(-d-) seven visits in any one week;~~]

[~~(-e-) care furnished on a visiting basis in the insured's home;~~]

[~~(-f-) services provided by a care provider as defined in this section;~~]

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

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

[~~(iii) Coverage is excluded for:~~]

[~~(I) home care visits paid for by Medicare or other government programs; and~~]

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

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

[~~(1) Requirement of uniformity for all Medicare supplement benefit plans. An issuer shall make available only those groups, packages or combinations of Medicare supplement benefits as described in this section, unless otherwise permitted by provisions of paragraph (2)(O) of this subsection and in §3.3325 of this subchapter. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plan "A," defined as the basic core plan of benefits in subsection (c)(2) of this section and described in paragraph (2)(A) of this subsection, and benefit plans "B" through "J,"~~

~~described in paragraph (2)(B) - (L) of this subsection. All benefit plans shall conform to the definitions set out in §3.3303 of this subchapter and §3.3304 of this subchapter (relating to Policy Definitions and Terms). Each benefit shall be structured in accordance with the format provided in subsection (c)(2) and (3) of this section. Each benefit plan shall list the benefits in the order shown in paragraph (2)(A) - (L) of this subsection. For purposes of this paragraph, "structure, language, and format" means style, arrangement and overall content of a benefit. In addition to the benefit plan designations required in this paragraph, an issuer may use other designations to the extent permitted by law.~~]

[~~(2) Make-up of Benefit Plans. Subparagraphs (A) - (O) of this paragraph set out the composition of benefit plans. Each benefit plan shall meet the requirements of this subchapter.~~]

[~~(A) Standardized Medicare Supplement Benefit Plan "A." Medicare supplement benefit Plan "A" shall include only the Core Benefits common to All Benefit Plans, as defined in subsection (c)(2) of this section.~~]

[~~(B) Standardized Medicare Supplement Benefit Plan "B." Medicare supplement benefit Plan "B" shall include only the Core Benefits as defined in subsection (c)(2) of this section, plus the Medicare Part A Deductible as defined in subsection (c)(3) of this section.~~]

[~~(C) Standardized Medicare Supplement Benefit Plan "C." Medicare supplement benefit Plan "C" shall include only the Core Benefit as defined in subsection (c)(2) of this section, 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 subsection (c)(3) of this section.~~]

[~~(D) Standardized Medicare Supplement Benefit Plan "D." Medicare supplement benefit Plan "D" shall include only the Core Benefit as defined in subsection (c)(2) of this section, 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 subsection (c)(3) of this section.~~

[~~(E) Standardized Medicare Supplement Benefit Plan "E." Medicare supplement benefit Plan "E" shall include only the Core Benefit as defined in subsection (c)(2) of this section, 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 subsection (c)(3) of this section.~~]

[~~(F) Standardized Medicare Supplement Benefit Plan "F." Medicare supplement benefit Plan "F" shall include only the Core Benefit as defined in subsection (c)(2) of this section, plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, One Hundred~~

~~Percent of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in subsection (c)(3) of this section.~~]

[~~(G) Standardized Medicare Supplement Benefit High Deductible Plan "F." Medicare supplement benefit high deductible Plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible Plan "F" deductible. The covered expenses include the Core~~ Benefit as defined in subsection (c)(2) of this section, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, 100% of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in subsection (c)(3) of this section. The annual high deductible Plan "F" deductible shall consist of out-of-pocket expenses, other than premiums for services covered by the Medicare supplement Plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.]

[~~(H) Standardized Medicare Supplement Benefit Plan "G." Medicare supplement benefit Plan "G" shall include only the Core Benefit as defined in subsection (c)(2) of this section, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Eighty 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 subsection (c)(3) of this section.~~]

[~~(I) Standardized Medicare Supplement Benefit Plan "H." Medicare supplement benefit Plan "H" shall include only the Core Benefit as defined in subsection (c)(2) of this section, 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 subsection (c)(3) of this section. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.~~]

[~~(J) Standardized Medicare Supplement Benefit Plan "I." Medicare supplement benefit Plan "I" shall include only the Core Benefit as defined in subsection (c)(2) of this section, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, One Hundred Percent 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 subsection (c)(3) of this section. The outpatient~~

~~prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.~~]

[~~(K) Standardized Medicare Supplement Benefit Plan "J." Medicare supplement benefit Plan "J" shall include only the Core Benefit as defined in subsection (c)(2) of this section, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent 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 subsection (c)(3) of this section. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.~~]

[~~(L) Standardized Medicare Supplement Benefit High Deductible Plan "J." Medicare supplement benefit high deductible Plan "J" shall include only the following: 100% of covered expenses following the payment of the annual high deductible Plan "J" deductible. The covered expenses include the Core Benefit as defined in subsection (c)(2) of this section, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, 100% of the Medicare Part B Excess Charges, Extended Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in subsection (c)(3) of this section. The annual high deductible Plan "J" deductible shall consist of out-of-pocket expenses, other than premiums for services covered by the Medicare supplement Plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "J" deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.~~]

[~~(M) Standardized Medicare supplement benefit Plan "K" shall include only the following:~~]

[~~(i) Coverage of 100% of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;~~]

[~~(ii) Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;~~]

[~~(iii) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;~~]

[~~(iv) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in clause (x) of this subparagraph;~~]

[~~(v) Skilled Nursing Facility Care: Coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in clause (x) of this subparagraph;~~]

[~~(vi) Hospice Care: Coverage for 50% of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in clause (x) of this subparagraph;~~]

[~~(vii) Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in clause (x) of this subparagraph;~~]

[~~(viii) Except for coverage provided in clause (ix) of this subparagraph, coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in clause (x) of this subparagraph;~~]

[~~(ix) Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and~~]

[~~(x) Coverage of 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in calendar year 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary.~~]

[~~(N) Standardized Medicare supplement benefit Plan "L" shall include only the following:~~]

[~~(i) The benefits described in subparagraph (M)(i), (ii), (iii) and (ix) of this paragraph;~~]

[~~(ii) The benefits described in subparagraph (M)(iv), (v), (vi), (vii) and (viii) of this paragraph, but substituting 75% for 50%; and~~]

[~~(iii) The benefit described in subparagraph (M)(x) of this paragraph, but substituting $2000 for $4000.~~]

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

Rule §3.3307. Loss Ratio Standards and Refund or Credit of Premiums.

(a) Minimum aggregate loss ratio standard. A Medicare supplement individual or group policy form may [~~shall~~] not be delivered or issued for delivery unless the individual or group policy form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregated benefits (not including anticipated refunds or credits) provided under the individual policy form or group policy form, on the basis of incurred claims experience or incurred health care expenses where coverage is provided by an HMO [~~a health maintenance organization~~] on a service, rather than reimbursement, basis and earned premiums for the applicable period, not including any changes in additional reserves[~~,~~] and in accordance with generally accepted actuarial principles and practices:

(1) at least 75 percent [~~75%~~] of the aggregate amount of premiums earned in the case of group policies; or

(2) at least 65 percent [~~65%~~] of the aggregate amount of premiums earned in the case of individual policies.

(b) HMO [~~Health maintenance organization~~] loss ratio standard. An HMO [~~A health maintenance organization~~] loss ratio, where coverage is provided on a service rather than reimbursement basis, must [~~shall~~] be calculated on the basis of incurred claims experience or incurred health care expenses and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health

care expenses where coverage is provided by an HMO may [~~a health maintenance organization shall~~] not include:

(1) home office and overhead costs;

(2) advertising costs;

(3) commissions and other acquisition costs;

(4) taxes;

(5) capital costs;

(6) administrative costs; and

(7) claims processing costs.

(c) Calendar-year [~~Calendar year~~] experience loss ratio standard. For the most recent calendar year, the ratio of incurred losses to earned premiums for all policies or certificates that [~~which~~] have been in force for three years or more, as of December 31st of the most recent year, must [~~shall~~] be equal to or greater than:

(1) at least 75 percent [~~75%~~] in the case of group policies; and

(2) at least 65 percent [~~65%~~] in the case of individual policies.

(d) Filing of rates and rating schedules. All filings of rates and rating schedules must [~~shall~~] demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions must [~~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. For individual or group policies issued before [~~prior to~~] March 1, 1992, the provisions of paragraph (3) of this subsection must be met with respect to expected claims in relation to premiums. For purposes of submitting a rate filing under this section, policy forms, whether for open or closed blocks of business, providing for similar benefits must [~~shall~~] be combined. But [~~However,~~] for purposes of the required combination set out in this section, issuers may distinguish between policy forms providing for similar benefits for individuals 65 years of age or over and policy forms providing for similar benefits for individuals under age 65. Once policy forms have been combined, they remain so for all rating purposes. When forms have been [~~so~~] combined, a rate revision request must [~~shall~~] not differentiate between the experience of the individual forms. Where significant inconsistencies between rate levels exist among [~~between~~] forms providing similar benefits, some deviation in rate revision must [~~shall~~] be allowed to reduce the significant inconsistencies.

(1) Each Medicare supplement policy or certificate form must [~~shall~~] be accompanied, on [~~upon~~] submission for approval, by an actuarial memorandum. The [~~Such~~] memorandum must [~~shall~~] be prepared and signed by a qualified actuary in accordance with generally accepted actuarial principles and practices, and must [~~shall~~] contain the information listed in the following subparagraphs:

(A) the form number that the actuarial memorandum addresses;

(B) a brief description of benefits provided;

(C) a schedule of rates to be used;

(D) a complete explanation of the rating process, including assumptions, claims data, methodology, and formulae used in developing the gross premium rates;

(E) a statement of what experience base will be used in future rate adjustments;

(F) a certification that the anticipated aggregate loss ratio is at least 65 percent [~~65%~~] (for individual coverage) or at least 75 percent [~~75%~~] (for group coverage), which [~~certification~~] should include a statement of the period over which the aggregate loss ratio is expected to be realized;

(G) a table of anticipated loss ratio experience for representative issue ages for each year from issue over the period during [~~of time over~~] which the aggregate loss ratio is to be realized; and

(H) a certification that the premiums are reasonable in relation to the benefits provided.

(2) Subsequent rate adjustment filings, except for those rates filed solely due to a change in the Part A calendar year deductible, must [~~shall~~] also provide an actuarial memorandum, prepared by a qualified actuary[~~,~~] in accordance with generally accepted actuarial principles and practices, which must [~~memorandum shall~~] contain the following information: [~~in the following subparagraphs.~~]

(A) the [~~The~~] form number addressed by the actuarial memorandum; [~~shall be included.~~]

(B) a [~~A~~] brief description of benefits provided; [~~shall be included~~].

(C) a [~~A~~] schedule of rates before and after the rate change; [~~shall be included~~].

(D) a [~~A~~] statement of the reason and basis for the rate change; [~~shall be included~~].

(E) a [~~A~~] demonstration and certification by the qualified actuary [~~shall be included~~] to show that the past plus future expected experience after the rate change, will result in an aggregate loss ratio equal to, or greater than, the required minimum aggregate loss ratio;[~~.~~]

(i) this [~~This~~] rate change and demonstration must [~~shall~~] be based on the experience of the named form in Texas only, if that experience is fully credible, as set out in paragraph (3) of this subsection;[~~.~~]

(ii) this [~~This~~] rate change and demonstration must [~~shall~~] be based on experience of the named form nationwide, with credibility factors as set out in paragraph (3) of this subsection applied, if the named form is used nationwide and the Texas experience is not fully credible;[~~.~~]

(iii) this [~~This~~] rate change and demonstration must [~~shall~~] be based on experience of the named form in Texas only, with credibility factors as set out in paragraph (3) of this subsection applied, if the named form is used in Texas only and the Texas experience is not fully credible;[~~.~~]

(F) for [~~For~~] policies or certificates in force less than three years, a demonstration [~~shall be included~~] to show that the third-year loss ratio is expected to be equal to[~~,~~] or greater than[~~,~~] the applicable percentage; and[~~.~~]

(G) a [~~A~~] certification by the qualified actuary that the resulting premiums are reasonable in relation to the benefits provided [~~shall be included~~].

(3) For purposes of this subsection, if a group or individual policy form has 2,000 or more policies in force, then full credibility (100 percent) must [~~(100%) shall~~] be given to the experience. If fewer than 500 policies are in force, then no credibility (0 percent) must [~~(0%) shall~~] be given to the experience. The principle of linear interpolation must [~~shall~~] be used for in force [~~in-force~~] numbers between 500 and 2,000. For group policy forms, the reference in this paragraph to the number of in force [~~in-force~~] policies means the number of in force [~~in-force~~] certificates under group policies. For purposes of this section, "in force" means either the average number of policies in force for the experience period used to support the need for a rate revision, or the number of policies in force as of the ending date of the experience period used to support the need for a rate revision. Once an issuer makes a decision as to which definition it will apply to a particular policy form, the [~~such~~] decision is irrevocable. An issuer may submit specific alternate credibility standards to the department for consideration. In order for an alternate standard of credibility to be acceptable for application, the issuer must demonstrate that the standards are based on sound actuarial principles, and that the resulting loss ratios are in substantial compliance with the requirements of subsections (a), (b), and (c) of this section.

(4) For individual policies issued before [~~prior to~~] March 1, 1992, the expected claims in relation to premiums must [~~shall~~] meet:

(A) the originally filed [~~originally-filed~~] anticipated loss ratio when combined with the actual experience since inception;

(B) a loss ratio of at least 65 percent [~~65%~~] when combined with actual experience beginning with June 1, 1996, to date; and

(C) a loss ratio of at least 65 percent [~~65%~~] over the entire future period for which the rates are computed to provide coverage.

(e) Annual filing of premium rates required. Every issuer of Medicare supplement policies and certificates issued before or after March 1, 1992, in this state must [~~shall~~] file annually its rates, rating schedule, and supporting documentation, including ratios of incurred losses to earned premiums, for the most recent calendar year broken down by calendar year of issue or by policy duration, for purposes of demonstrating that the issuer is in compliance with the loss ratio standards[~~,~~] and for approval by the department [~~Department~~] in accordance with the filing requirements of this section and the requirements of §3.3323 of this title (relating to Increases to Premium Rates). The supporting documentation must [~~shall~~] also demonstrate, in accordance with actuarial standards of practice using reasonable assumptions, that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The [~~Such~~] demonstration must [~~shall~~] exclude active life reserves. An expected third-year loss ratio that [~~which~~] is greater than or equal to the applicable percentage must [~~shall~~] be demonstrated for policies or certificates in force less than three years. The annual filing requirements in this subsection must [~~shall~~] be as follows:

(1) the NAIC Medicare supplement experience exhibit, which summarizes the experience of each individual form with business in force in Texas;

(2) the NAIC Medicare supplement experience exhibit, which summarizes the experience of each group form with business in force in Texas;

(3) rates and rating schedules for each form with business in force in Texas;

(4) a certification by the qualified actuary that the policies or certificates in force less than three years are anticipated to produce a third-year loss ratio that [~~which~~] is greater than or equal to the applicable loss ratio percentage; and

(5) a certification by the qualified actuary that the expected losses in relation to premiums over the entire period for which the policy is rated comply with the required minimum aggregate loss ratio standard.

(f) Refund or credit calculation. An issuer must use the online reporting form found on the department's website at www.tdi.texas.gov and electronically submit the data required by this section, which is [~~shall collect and file with the commissioner by May 31 of each year the data~~] contained in Figure: 28 TAC §3.3307(f) of [~~the "Medicare Supplement Refund Calculation Form," published as Figure 1 to~~] this section [~~, for each type in a standard Medicare supplement benefit plan. This form is published by the Texas Department of Insurance and copies of this form are available from the Life/Health Group, Mail Code 106-1A of the Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104~~]. Issuers must submit the report to the department no later than May 31 of each year.

Figure: 28 TAC §3.3307(f)

TEXAS DEPARTMENT OF INSURANCE
MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR THE CALENDAR YEAR _____

TYPE[1] _____SMSBP[2]_____
For the State of Texas _____
Company Name _____
NAIC Group Code _____NAIC Company Code _____
Address _____
Person Completing this Exhibit _____
Title _____Telephone _____

☐ This company did not have any Medicare supplement business written or policies or certificates in force in Texas during the reporting year.

Line		(I) Earned Premium[3]	(II) Incurred Claims[4]
1.	Current Year's Experience		
	a. Total (all policy years)	_____	_____
	b. Current year's issues[5]	_____	_____
	c. Net (for reporting purposes) (line 1a - line 1b)	_____	_____
2.	Past Year's Experience (all policy years)	_____	_____
3.	Total Experience (line 1c + line 2)	_____	_____
4.	Refunds Last Year (excluding interest)	_____	
5.	Refunds From all Previous Reporting Years (excluding interest)	_____	
6.	Refunds Since Inception (excluding interest) (line 4 + line 5)	_____	
7.	Benchmark Ratio Since Inception (Ratio 1 automatically calculated from Benchmark form)	_____	

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select only. (Ensure you have chosen the correct "Type." Changing the "Type" after data has been entered in the Benchmark page will result in the deletion of all data entered in the Benchmark page.)
[2] SMSBP means Standardized Medicare Supplement Benefit Plan. Use "PS" for pre-standardized plans.
[3] Includes Modal Loadings and Fees Charged.
[4] Excludes Active Life Reserves.
[5] This will be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios."

TEXAS DEPARTMENT OF INSURANCE
MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR THE CALENDAR YEAR _____
(Continued)

TYPE [1]_____SMSBP[2]_____
Company Name _____

8. Experienced Ratio Since Inception (Ratio 2) _____
   (line 3, col. II) / (line 3, col. I - line 6)

9. Life Years Exposed Since Inception _____
   If (line 8 < line 7) AND (line 9 > 499), proceed; otherwise, stop.

10. Tolerance Permitted (obtained from credibility table) _____

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	

11. Adjustment to Incurred Claims for Credibility (Ratio 3) _____
    (line 8 + line 10)

    If (line 11 > line 7), a refund/credit is not required; otherwise, proceed.

12. Adjusted Incurred Claims _____
    (line 3, col. I - line 6) x (line 11)

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select only.
[2] SMSBP means Standardized Medicare Supplement Benefit Plan. Use "PS" for pre-standardized plans.

TEXAS DEPARTMENT OF INSURANCE
MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR THE CALENDAR YEAR _____
(Continued)

TYPE [1]_____SMSBP[2]_____
Company Name _____

13. Refund _____
[line 3, col. I - line 6 - (line 12 / line 7)]

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year (the de minimis amount), then there is no refund. Otherwise, the amount on line 13 will be refunded or credited, and a description of the refund or credit against premiums to be used must be provided in the Distribution Methodology field.

De minimis Amount _____
(.005 x annualized premium in force on 12/31)

Distribution Methodology

☐ By checking this box, I attest that all information contained in this form is a full and true statement in accordance with the instructions provided to the best of my information, knowledge, and belief.

_____
Name

_____
Title

_____
Date

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select only.
[2] SMSBP means Standardized Medicare Supplement Benefit Plan. Use "PS" for pre-standardized plans.

TEXAS DEPARTMENT OF INSURANCE
REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES
FOR THE CALENDAR YEAR _____

TYPE [1]_____SMSBP[2]_____
Company Name _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
		2.770		0.442		0.000		0.000		0.40
		4.175		0.493		0.000		0.000		0.55
		4.175		0.493		1.194		0.659		0.65
		4.175		0.493		2.245		0.669		0.67
		4.175		0.493		3.170		0.678		0.69
		4.175		0.493		3.998		0.686		0.71
		4.175		0.493		4.754		0.695		0.73
		4.175		0.493		5.445		0.702		0.75
		4.175		0.493		6.075		0.708		0.76
		4.175		0.493		6.650		0.713		0.76
		4.175		0.493		7.176		0.717		0.76
		4.175		0.493		7.655		0.720		0.77
		4.175		0.493		8.093		0.723		0.77
		4.175		0.493		8.493		0.725		0.77
		4.175		0.493		8.684		0.725		0.77
Total:		(k):		(I):		(m):		(n):		

Benchmark Ratio Since Inception: (l+n) / (k+m): _____ (Ratio 1)

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select only.
[2] SMSBP means Standardized Medicare Supplement Benefit Plan. Use "PS" for pre-standardized plans.
[3] Data entered must be for the calendar year displayed.
[4] For the calendar year on the appropriate line in column (a), the premium earned during that year is for policies issued in that year.
[5] These loss ratios are not explicitly used in computing the benchmark 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.

TEXAS DEPARTMENT OF INSURANCE
REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR THE CALENDAR YEAR _____

TYPE [1]_____SMSBP[2]_____
Company Name _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
		2.770		0.507		0.000		0.000		0.46
		4.175		0.567		0.000		0.000		0.63
		4.175		0.567		1.194		0.759		0.75
		4.175		0.567		2.245		0.771		0.77
		4.175		0.567		3.170		0.782		0.80
		4.175		0.567		3.998		0.792		0.82
		4.175		0.567		4.754		0.802		0.84
		4.175		0.567		5.445		0.811		0.87
		4.175		0.567		6.075		0.818		0.88
		4.175		0.567		6.650		0.824		0.88
		4.175		0.567		7.176		0.828		0.88
		4.175		0.567		7.655		0.831		0.88
		4.175		0.567		8.093		0.834		0.89
		4.175		0.567		8.493		0.837		0.89
		4.175		0.567		8.684		0.838		0.89
Total:		(k):		(I):		(m):		(n):		

Benchmark Ratio Since Inception: (l+n) / (k+m): _____ (Ratio 1)

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select only.
[2] SMSBP means Standardized Medicare Supplement Benefit Plan. Use "PS" for pre-standardized plans.
[3] Data entered must be for the calendar year displayed.
[4] For the calendar year on the appropriate line in column (a), the premium earned during that year is for policies issued in that year.
[5] These loss ratios are not explicitly used in computing the benchmark 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.

Insurance Company Name ____

Form Numbers for Medicare Supplement Refund Calculation
for Plan _________________________________

Please enter only one form number per line.	Please enter only one form number per line.

Print Form   Submit by Email

(1) 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 must [~~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 must [~~shall~~] be excluded.

(2) A refund or credit will [~~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 must [~~shall~~] include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary [~~secretary of health and human services~~], but in no event may [~~shall~~] it be less than the average rate of interest for 13-week treasury notes. A refund or credit against premiums due must [~~shall~~] be made by September 30 following the experience year on [~~upon~~] which the refund or credit is based.

(3) For an individual or group policy or certificate issued before [~~prior to~~] March 1, 1992, the issuer, for purposes of complying with this subsection, must [~~shall~~] make the refund or credit calculation separately for all individual policies combined and all group policies combined for experience after June 1, 1996.

[~~Figure: 28 TAC §3.3307(f)(3)~~]

(g) Premium adjustments to conform with minimum standards for loss ratios. As soon as practicable, but before [~~prior to~~] the effective date of enhancements to Medicare benefits, every issuer of Medicare supplement insurance policies, contracts, or coverage in this state must [~~shall~~] file with the commissioner, in accordance with the applicable filing procedures of this state, the items required in paragraphs (1) and (2) of this subsection.

(1) Issuers must file the appropriate [~~Appropriate~~] premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or contracts [~~shall be filed~~]. Documents necessary to justify the adjustment must [~~shall~~] accompany the filing.

(A) Every issuer of Medicare supplement insurance or benefits to a resident of this state under [~~pursuant to the~~] Insurance Code Chapter 1652 must [~~, Article 3.74 shall~~] make premium adjustments:

(i) necessary to produce [~~product~~] an expected loss ratio under the policy or contract that [~~as~~] will conform with the minimum loss ratio standards for Medicare supplement policies; and

(ii) expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premium by the issuer for the Medicare supplement insurance policies or contracts.

(B) No premium adjustment that [~~which~~] would modify the loss ratio experience under the policy, other than the adjustments described in this subsection, should be made with respect to a policy at any time other than on [~~upon~~] its renewal date or anniversary date.

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

(2) Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare must [~~shall~~] be filed. The riders, endorsements, or policy forms must [~~shall~~] provide a clear description of the Medicare supplement benefits provided by the policy or contract.

(h) Maintenance of data. Incurred claims and earned premium experience must [~~shall~~] be maintained for each policy form with business in force in Texas, by calendar year of issue, and must [~~shall~~] be made available to the department [~~Texas Department of Insurance~~].

§3.3308. Required Disclosure Provisions.

(a) General rules.

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

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the policyholder, or by which the issuer exercises a specifically reserved right under a Medicare supplement policy, or by which the issuer 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 [~~which~~] reduce or eliminate benefits or coverage in the policy must [~~shall~~] require signed acceptance by the policyholder. After the date of issue of the policy or

certificate, any rider or endorsement that [~~which~~] increases benefits or coverage with concomitant increase in premium during the policy term must [~~shall~~] be agreed to in writing and signed by the policyholder[~~,~~] unless the benefits are required by the minimum standards for Medicare supplement insurance policies, or unless the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the additional premium charge must [~~shall~~] be set forth in the policy.

(3) Medicare supplement policies may [~~shall~~] not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or similar words and phrases [~~of similar import~~].

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions:

(A) the limitations must [~~shall~~] appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations;"

(B) the policy or certificate must [~~shall~~] define the term "preexisting condition" and must [~~shall~~] provide an explanation of the term in its accompanying outline of coverage; and

(C) the policy or certificate must [~~shall~~] include a provision explaining the reduction of the preexisting condition limitation for individuals who [~~that~~] qualify under §3.3306(b)(1)(A) of this title (relating to Minimum Benefit Standards), §3.3312(a)(2) of this title (relating to Guaranteed Issue for [~~to~~] Eligible Persons), or §3.3324(c) and (d) of this title (relating to Open Enrollment).

(5) Medicare supplement policies and certificates must [~~shall~~] have a notice prominently printed on the first page or attached to the first page [~~thereto~~] stating in substance that the policyholder or certificate holder has [~~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, the insured person is not satisfied for any reason.

(6) Issuers of accident and sickness policies, certificates, or subscriber contracts that [~~which~~] provide hospital or medical-expense [~~medical expense~~] coverage on an expense-incurred [~~expense incurred~~] or indemnity basis, to persons [~~a person(s)~~] eligible for Medicare must [~~shall~~] provide to those applicants a *Guide to Health Insurance for People with Medicare (Guide)* in the form developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services in no smaller than 12-point type.

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

(B) If a *Guide* [~~Guide~~] incorporating the latest statutory changes is not available from a government agency, companies may comply with this provision by modifying the latest available *Guide* [~~Guide~~] to the extent required by applicable law.

(C) Except as provided in this section, delivery of the *Guide* [~~Guide~~] must [~~shall~~] be made whether or not any [~~such~~] policies, certificates, subscriber contracts, or evidences of coverage are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this regulation.

(D) Except in the case of direct response issuers, delivery of the *Guide* [~~Guide~~] must [~~shall~~] be made to the applicant at the time of application, and acknowledgment of receipt of the *Guide* [~~Guide~~] must [~~shall~~] be obtained from the applicant by the issuer. Issuers [~~provided, however, issuers~~] must [~~shall~~] deliver the *Guide* [~~Guide~~] to the applicant for a direct response Medicare supplement policy on [~~upon~~] request, but not later than at the time the policy is delivered.

(7) Except as otherwise provided in this section, the terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and similar words or phrases [~~of similar import~~] may not be used unless the policy is issued in compliance with §3.3306 of this title.

(b) Outline of coverage requirements for Medicare supplement policies.

(1) Issuers of Medicare supplement coverage in this state must [~~shall~~] provide an outline of coverage to all applicants, including certificate holders under group policies, at the time application is presented to the prospective applicant[~~,~~] and, except for direct-response [~~direct response~~] policies, must [~~shall~~] obtain an acknowledgment of receipt of the [~~such~~] outline from the applicant.

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

(c) Form for outline of coverage. In providing outlines of coverage to applicants under [~~pursuant to~~] the requirements of subsection (b)(1) of this section, insurers must [~~shall~~] use a form that [~~which~~] complies with the requirements of this subsection. The outline of coverage must contain each of the following four parts in the following order: a cover page, premium information, disclosure pages, and

charts displaying the features of each benefit plan offered by the issuer. The outline of coverage must [~~shall~~] be in the language and format prescribed in paragraphs (1) and (2) of this subsection in no less than 12-point type.

(1) All plans must [~~shall~~] be shown on the cover page, and the plans [~~plan(s)~~] that are offered by the issuer must [~~shall~~] be prominently identified. Premium information for plans that are offered must [~~shall~~] be shown on the cover page or immediately following the cover page and must [~~shall~~] be prominently displayed. The premium and mode must [~~shall~~] be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant must [~~shall~~] be illustrated.

(2) The items in subparagraphs (A) - (C) of this paragraph must [~~shall~~] be included in the outline of coverage in addition to the items specified in the plan-specific outline-of-coverage forms.

(A) Dollar amounts that [~~which~~] are shown in parentheses for each of the plan-specific charts on the following pages are for the calendar year in which the charts were published. Issuers must [~~shall~~], for each plan offered, appropriately complete outline-of-coverage-chart statements about amounts to be paid by Medicare, the plan, and the covered person by replacing the amount in parentheses with the dollar amount corresponding to each covered service for the applicable calendar year benefit period.

(B) The outline of coverage must include an explanation of any limitations and exclusions. Those limitations and exclusions resulting from Medicare program provisions may be disclosed [~~as such~~] by reference and need not be explained in their entirety. All limitations and exclusions related to preexisting conditions [~~,~~] and all other limitations and exclusions not resulting from Medicare regulations must be fully explained in the outline of coverage.

(C) The outline of coverage must include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium on [~~upon~~] the death of an insured or on the surrender of the policy or certificate. If the policy contains these [~~such~~] provisions, a description of the provisions [~~them~~] must be included.

(D) The outline of coverage for Medicare Select policies or certificates must [~~shall~~] include information regarding grievance procedures that [~~which~~] meet the requirements of §3.3325(m) of this title [~~subchapter~~] (relating to Medicare Select Policies, Certificates, and Plans of Operation).

(E) The commissioner adopts [~~by reference~~] the Outline of Coverage form, [~~Form No.~~] LHL 050 Rev. 12/17[~~06/09~~]. This form [~~which~~] contains a chart of benefits for each of the standard Medicare supplement plans and required disclosures applicable to policies sold with an effective date for

coverage of June 1, 2010, or later. Issuers must begin using form LHL 050 Rev. 12/17 no later than July 1, 2018. [~~The form is available at www.tdi.state.tx.us/forms/form10other.html.~~]

Figure: 28 TAC §3.3308(c)(2)(E)

[~~(F) The commissioner adopts by reference the Outline of Coverage form, Form No. LHL 050 Rev. 12/04, which contains a chart of benefits for each of the standard Medicare supplement plans and required disclosures applicable to policies sold with an effective date for coverage prior to June 1, 2010, and on or after March 1, 1992. The form is available at www.tdi.state.tx.us/forms/form10other.html.~~]

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Basic Benefits:

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

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out of pocket limit $[5,120] paid at 100% after limit reached	Out of pocket limit $[2,560] paid at 100% after limit reached		

* Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[2,200] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $[2,200]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

PREMIUM INFORMATION [Boldface Type]

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

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

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

RIGHT TO RETURN POLICY [Boldface Type]

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

POLICY REPLACEMENT [Boldface Type]

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

NOTICE [Boldface Type]

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

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

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

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

LIMITATIONS AND EXCLUSIONS [Boldface Type]

[Include language regarding any limitations or exclusions including those related to preexisting conditions as required by 28 Texas Administrative Code §3.3308(c).]

REFUND OF PREMIUM [Boldface Type]

[Include language regarding refund, or no refund, of premium upon death of the insured or policy cancellation as required by 28 Texas Administrative Code §3.3308(c).]

GRIEVANCE PROCEDURES (Boldface Type)

[Include language regarding grievance procedures as required by 28 Texas Administrative Code §3.3308(c)(2)(D).]

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

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

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

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts under 28 Texas Administrative Code § 3.3306(c)(4).]

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

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

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

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

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible	✓	✓	✓	✓	50%	75%	50 %	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in [2017][2]					$[5,120][2]	$[2,560][2]				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $[2,200] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

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 $[1,316]	$0	$[1,316] (Part A deductible)
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] 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 $[164.50] a day	$0	Up to $[164.50] 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			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ Coinsurance	$0

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – 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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (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 $[1,316]	$[1,316] (Part A deductible)	$0
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] 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 $[164.50] a day	$0	Up to $[164.50] 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			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – 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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,316]	$[1,316] (Part A deductible)	$0
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] 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 $[164.50] a day	Up to $[164.50] 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			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $[183] of Medicare Approved Amounts*	$0	$[183] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$[183] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – 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 $[183] of Medicare Approved Amounts*	$0	$[183] (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $[1,316]	$[1,316] (Part A deductible)	$0
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] 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 $[164.50] a day	Up to $[164.50] 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			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – 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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN D

OTHER BENEFITS – NOT COVERED BY MEDICARE

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 F or HIGH DEDUCTIBLE PLAN F

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

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
[**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $[2,200] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[2,200]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2,200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,200] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,316]	$[1,316] (Part A deductible)	$0
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] 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 $[164.50] a day	Up to $[164.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F

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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2,200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,200] DEDUCTIBLE,**] YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

[**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $[2,200] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[2,200]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2,200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,200] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[183] of Medicare Approved Amounts*	$0	$[183] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$[183] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2,200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,200] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
- First $[183] of Medicare Approved Amounts*	$0	$[183] (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2,200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,200] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G or HIGH DEDUCTIBLE 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.

[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $[2,200] deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $[2,200]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2,200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,200] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,316]	$[1,316] (Part A deductible)	$0
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] 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 $[164.50] a day	Up to $[164.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

PLAN G or HIGH DEDUCTIBLE PLAN G

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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2,200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,200] DEDUCTIBLE,**] YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN G or HIGH DEDUCTIBLE PLAN G

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

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

[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $[2,200] deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $[2,200]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2,200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,200] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G or HIGH DEDUCTIBLE PLAN G

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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Unless Part B deductible has been met)
- 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 K

♦ You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[5,120] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,316]	$[658] (50% of Part A deductible)	$[658] (50% of Part A deductible) ♦
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] 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 $[164.50] a day	Up to $[82.25] a day (50% of Part A coinsurance)	Up to $[82.25] a day (50% of Part A coinsurance) ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50% ♦
Additional amounts	100%	$0	$0

PLAN K

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/ coinsurance	50% of Medicare copayment/ coinsurance ♦

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible) ♦
Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare Approved Amounts	Remainder of Medicare Approved Amounts	All costs above Medicare Approved Amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $[5,120])
BLOOD			
First 3 pints	$0	50%	50% ♦
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN K

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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible) ♦
- Remainder of Medicare Approved Amounts	80%	10%	10% ♦

PLAN L

♦ You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[2,560] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,316]	$[987] (75% of Part A deductible)	$[329] (25% of Part A deductible) ♦
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] 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 $[164.50] a day	Up to $[123.38] a day (75% of Part A coinsurance)	Up to $[41.13] a day (25% of Part A coinsurance) ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25% ♦
Additional amounts	100%	$0	$0

PLAN L

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/ coinsurance	25% of copayment/ coinsurance ♦

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible) ♦
Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare Approved Amounts	Remainder of Medicare Approved Amounts	All costs above Medicare Approved Amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $[2,560])
BLOOD			
First 3 pints	$0	75%	25% ♦
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN L

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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible) ♦
- Remainder of Medicare Approved Amounts	80%	15%	5% ♦

PLAN M

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

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 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 $[1,316]	$[658] (50% of Part A deductible)	$[658] (50% of Part A deductible)
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] 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 $[164.50] a day	Up to $[164.50] 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			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN M

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – 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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN M

OTHER BENEFITS—NOT COVERED BY MEDICARE

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 N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,316]	$[1,316] (Part A deductible)	$0
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] 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 $[164.50] a day	Up to $[164.50] 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			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to the hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
- 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

(d) Notice requirements.

(1) As soon as practicable, but no later than 30 days before [~~prior to~~] the annual effective date of any Medicare benefit changes, every issuer providing Medicare supplement coverage to a resident of this state must [~~shall~~] notify its policyholders, contract holders, and certificate holders of modifications it has made to Medicare supplement insurance policies, contracts, or certificates. The notice must [~~shall~~]:

(A) include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement insurance policy, contract, or certificate; and

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

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

(3) The notice may [~~shall~~] not contain or be accompanied by any solicitation.

(4) Issuers must [~~shall~~] comply with any notice requirements of the MMA.

§3.3312. Guaranteed Issue for Eligible Persons.

(a) Guaranteed issue.

(1) Eligible persons are those individuals described in subsection (b) of this section who seek to enroll under the Medicare supplement policy during the period specified in subsection (d) of this section, and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer must not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (c) of this section that is offered and is available for issuance to newly enrolled individuals by the issuer, and must not discriminate in the pricing of a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and must not impose an exclusion of benefits based on a preexisting condition under a Medicare supplement policy.

(b) Eligible persons [~~Persons~~]. An eligible person is an individual described in any of the following paragraphs:

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

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under §1894 of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare Advantage plan:

(A) the certification of the organization or plan has been terminated; or

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

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

(D) the individual demonstrates, in accordance [~~accord~~] with guidelines established by the Secretary, that:

(i) the organization offering the plan substantially violated a material provision of the organization's contract under 42 U.S.C. Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an individual on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide the covered care in accord with applicable quality standards; or

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

(E) the individual meets other exceptional conditions as the Secretary may provide.

(3) The individual is enrolled with an entity listed in subparagraphs (A) - (D) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) of this subsection:

(A) an eligible organization under a contract under §1876 of the Social Security Act (Medicare cost);

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

(C) an organization under an agreement under §1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(D) an organization under a Medicare Select policy; and

(4) the individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(A) of the insolvency of the issuer or bankruptcy of the nonissuer organization; or of other involuntary termination of coverage or enrollment under the policy;

(B) the issuer of the policy substantially violated a material provision of the policy; or

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

(5) the individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under §1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under §1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of the subsequent enrollment (during which time the individual is permitted to terminate the subsequent enrollment under §1851(e) of the Social Security Act); or

(6) the individual, on [~~upon~~] first becoming enrolled in Medicare Part B for benefits at age 65 or older, enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE

provider under §1894 of the Social Security Act, and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.

(7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (c)(4) of this section.

(8) The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

(9) The individual meets the following requirements:

(A) the individual was enrolled in both the federal Medicare program and the Texas Health Insurance Pool on December 31, 2013; and

(B) the individual's Pool coverage terminated on or after December 31, 2013.

(c) Products to which eligible persons are entitled. [~~Which Eligible Persons are Entitled. The Medicare supplement policy to which eligible persons are entitled under:~~]

(1) Persons described by subsection [~~Subsection~~] (b)(1), (2), (3), (4), (8), and (9) of this section are entitled to [~~is~~] a Medicare supplement policy that [~~which~~] has a benefit package classified as follows:

(A) Plan A, B, C, F (including F with a High Deductible [~~high deductible~~]), K, or L offered by any issuer, for an individual 65 years of age or older who first became eligible for Medicare before January 1, 2020, except that for persons under 65 years of age, it is a policy that [~~which~~] has a benefit package classified as Plan A; or

(B) Plan A, B, D, G (including G with a High Deductible), K, or L offered by any issuer, for a 2020 newly eligible individual who is 65 years of age or older, except that for persons under 65 years of age, it is a policy that has a benefit package classified as Plan A.

(2) Persons described by subsection [~~Subsection~~] (b)(5) of this section are entitled to [~~is~~] the same Medicare supplement policy in which the individual was most recently [~~previously~~] enrolled, if available from the same issuer[~~,~~] or, if not available, a policy described in paragraph (1) of this subsection. If [~~After December 31, 2005, if~~] the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, the

Medicare supplement policy described in this paragraph is the policy available from the same issuer but modified to remove outpatient prescription drug coverage, or at the election of the policyholder, a policy described in paragraph (1) of this subsection.

(3) Persons described by subsection [~~Subsection~~] (b)(6) of this section are entitled to [~~must include~~] any Medicare supplement policy offered by any issuer, with the exception of plans C or F (including F with a High Deductible) for a 2020 newly eligible individual.

(4) Persons described by subsection [~~Subsection~~] (b)(7) of this section are entitled to [~~is~~] a Medicare supplement policy that has a benefit package classified as follows:

(A) Plan A, B, C, F (including F with a High Deductible [~~high deductible~~]), K, or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage, for an individual who first became eligible for Medicare before January 1, 2020; or

(B) Plan A, B, D, G (including G with a High Deductible), K, or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage, for a 2020 newly eligible individual.

(d) Guaranteed issue time period [~~Issue Time Period~~].

(1) In the case of an individual described in subsection (b)(1) of this section:

(A) for a plan that supplements the benefits under Medicare, the guaranteed issue period begins on the later of:

(i) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, the date the individual receives notice that a claim has been denied because of the [~~such~~] termination or cessation); or

(ii) the date the applicable coverage terminates or ceases; and ends 63 days later; or

(B) for a plan that is primary to the benefits under Medicare, the guaranteed issue period begins on the later of:

(i) the date the individual receives a notice of termination or cessation of all health benefits (or if a notice is not received, the date the individual receives notice that a claim has been denied because of the [~~such~~] termination or cessation); or

(ii) the date the applicable coverage terminates or ceases; and ends 63 days later.

(2) In [~~in~~] the case of an individual described in subsection (b)(2), (3), (5), or (6) of this section whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.[~~;~~]

(3) In [~~in~~] the case of an individual described in subsection (b)(4)(A) of this section, the guaranteed issue period begins on the earlier of the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.[~~;~~]

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

(5) In [~~in~~] the case of an individual described in subsection (b)(7) of this section, the guaranteed issue period begins on the date the individual receives notice under §1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.[~~;~~]

(6) In [~~in~~] the case of an individual described in subsection (b) of this section, but not described in paragraphs (1) - (5) of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date of disenrollment.[~~; and~~]

(7) In [~~in~~] the case of an individual described in subsection (b)(9) of this section, the guaranteed issue period begins on the date that the individual's coverage in the Texas Health Insurance [~~Risk~~] Pool terminates and ends 63 days later.

(e) Extended Medicare supplement access [~~Supplement Access~~] for interrupted trial periods [~~Interrupted Trial Periods~~].

(1) In the case of an individual described in subsection (b)(5) of this section (or deemed to be so described[~~,~~] under this paragraph), whose enrollment with an organization or

provider described in subsection (b)(5) of this section is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another organization or provider, the subsequent enrollment will be deemed to be an initial enrollment as described in subsection (b)(5) of this section.

(2) In the case of an individual described in subsection (b)(6) of this section (or deemed to be so described[~~,~~] under this paragraph), whose enrollment with a plan or in a program described in subsection (b)(6) of this section is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another plan or program, the subsequent enrollment will be deemed to be an initial enrollment as described in subsection (b)(6) of this section.

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

§3.3316. Filing Requirements for Out-of-State Group Policies.

Every issuer providing group Medicare supplement insurance benefits to a resident of this state under [~~pursuant to~~ ~~the~~] Insurance Code Chapter 1652 must [~~, Article 3.74, shall~~], for information purposes, file with the department's Life and Health Lines Office [~~Life/Health Group of the Texas Department of Insurance~~] a copy of any master policy issued in connection with any certificate used in this state; all such certificates must [~~shall~~] be filed in accordance with the filing requirements and procedures applicable to group Medicare supplement policies issued in this state.

§3.3317. Permitted Compensation Arrangements.

(a) An issuer or other entity designated in [~~the~~] Insurance Code §1652.003 [~~, Article 3.74, §1(a),~~] may provide commission or other compensation to an agent for the sale of a Medicare supplement policy or certificate only if the first-year commission or other first-year compensation is no more than 200 percent [~~200%~~] of the commission or other compensation paid for selling or servicing the policy or certificate in the first renewal year, or the first 12-month service period

immediately following the initial 12-month service period of the policy in instances where premium payment is other than on an annual basis.

(b) The commission or other compensation provided in the second and subsequent renewal years where payment of premium is on an annual basis, or the second and subsequent 12-month service periods of the policy in instances where premium payment is other than on an annual basis, must be the same as that provided in the first renewal year, or first 12-month service period of the policy in instances where premium payment is other than on an annual basis, and must be provided for a reasonable number of renewal years, or successive 12-month service periods, but not less than six years following the inception of the first renewal year in the instance of premium payment on an annual basis, or the 12-month service period immediately following the initial 12-month service period of the policy in instances where premium payment is other than on an annual basis.

(c) No issuer may [~~shall~~] provide compensation to its agents and no agent may [~~shall~~] receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

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

§3.3323. Increases to Premium Rates.

Premium rates, rating schedules, and supporting documentation for a Medicare supplement policy or certificate to be used in this state must [~~shall~~] be filed with the department [~~Texas Department of Insurance~~] and approved by the commissioner. Any request for an increase to rates for Medicare supplement policies or certificates issued before or after March 1, 1992, is subject to review by and hearing before the commissioner if one or more of the following conditions, as determined by an actuary for the department, is present: [~~.~~]

(1) The increase, exclusive of any increase occasioned by changes in the laws regulating Medicare supplement coverages, is not necessary to maintain an anticipated lifetime loss ratio at least equal to the minimum that is required by statute and set out in §3.3307 of this title (relating to Loss Ratio Standards and Refund or Credit of Premiums).

(2) An increase to premium has been effected on the same block or blocks of business within the preceding 12 months.

(3) An increase to premium would result in unfair discrimination, as provided in [~~the~~] Insurance Code Chapter 544 [~~, Article 21.21, §4(7)(b)~~], between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for a policy or contract.

(4) An increase to premium would result in the benefits offered under the policy form to be unreasonable in relation to the premiums charged.

(5) An increase to premium would have the practical effect of altering the rating structure of the policy form to which it is applied, or would create a new set of rating criteria under the [~~such~~] policy form.

(6) A contemplated increase to premium has the practical effect of resulting in a series of planned future increases to premium rather than a one-time increase.

§3.3324. Open Enrollment.

(a) No issuer may [~~shall~~] deny or condition the issuance or [~~of~~] effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of [~~such~~] 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 a policy or certificate is submitted before [~~prior to~~] or during the six-month period beginning with the first day of the first month in which an individual is first enrolled for benefits under Medicare Part B. No issuer may [~~shall~~] engage in a premium rating practice that [~~which~~] results in higher premiums for any policy solely because the [~~such~~] policy is issued under [~~pursuant to~~] the provisions of this section. For individuals 65 years of age or older when first enrolled for benefits under Medicare Part B who apply for Medicare supplement coverage under this subsection, each Medicare supplement policy and certificate currently available from an issuer must [~~shall~~] be made available to all applicants without regard to age.

(b) The provisions of paragraphs (1) and (2) [~~(3)~~] of this subsection apply to Medicare supplement issuers with respect to persons who qualify for Medicare before attaining 65 years of age.

(1) An issuer must comply with the first two sentences of subsection (a) of this section with respect to a person who:

(A) qualifies for Medicare before attaining 65 years of age, who first enrolls for benefits under Medicare Part B on or after January 1, 1997, and who applies for a Medicare supplement policy or certificate during the period of eligibility described in subsection (a) of this section; or

(B) enrolled in Medicare Part B before attaining 65 years of age, who applies for a Medicare supplement policy or certificate upon attaining 65 years of age, during the period of eligibility described in subsection (a) of this section that would apply if the person first enrolled in Medicare Part B on [~~upon~~] attaining 65 years of age.

(2) An issuer must make available, at a minimum, Plan A of the standard Medicare supplement plans to individuals who qualify under this subsection.

[~~(3) An issuer must comply with the provisions of this subsection with respect to a person who:~~]

[~~(A) enrolled for Medicare Part B benefits before attaining 65 years of age during the period beginning March 1, 1992 and ending January 1, 1997;~~]

[~~(B) was not otherwise eligible to apply for a Medicare supplement policy or certificate on a guaranteed issue basis during that time period; and~~]

[~~(C) applies for a Medicare supplement policy or certificate during the period of eligibility beginning January 1, 1997 and ending July 1, 1997.~~]

(c) If an applicant qualifies under subsection (a) of this section, is 65 years of age or older, and submits an application during the [~~time~~] period referenced in subsection (a) of this section and, as of the date of application:

(1) has had a continuous period of creditable coverage of at least six months, the issuer may [~~shall~~] not exclude benefits based on a preexisting condition; or

(2) has had a continuous period of creditable coverage that is less than six months, the issuer must [~~shall~~] reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date.

(d) Except as provided in subsection (c) of this section, §3.3312 of this title [~~chapter~~] (relating to Guaranteed Issue for Eligible Persons), and §3.3306(b)(1)(A) of this title [~~chapter~~] (relating to Minimum Benefit Standards), subsection (a) of this section may [~~shall~~] not be construed as preventing the exclusion of benefits under a policy during the first six months[~~,~~] based

on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

(e) The following examples illustrate the application of subsection (c)(1) and (2) of this section, as prescribed by the Secretary:

(1) Individual A— [~~:~~] No preexisting condition exclusion period. Relevant creditable coverage history: Individual A had coverage under an individual policy for four months beginning on May 1, 1998, through August 31, 1998, followed by a gap in coverage of 61 days until October 31, 1998. Individual A had coverage under an individual health plan beginning on November 1, 1998, for three months through January 31, 1999, followed by a gap in coverage of 59 days or until March 31, 1999, on which date Individual A submitted an application for a Medicare supplement policy. Under this example, the Medicare supplement issuer may not apply a preexisting condition exclusion period because Individual A has seven months of creditable coverage without a gap in coverage greater than 63 days.

(2) Individual B— [~~:~~] Subject to a three-month [~~three months~~] preexisting condition exclusion period. Relevant creditable coverage history: Individual B is covered under an individual health insurance policy for one month beginning May 1, 1998, through May 31, 1998, followed by a gap in coverage of 61 days from June 1, 1998, through July 31, 1998. On August 1, 1998, Individual B is covered under an association health plan for two months through September 30, 1998, followed by a gap in coverage of 31 days or until October 31, 1998, on which date Individual B [~~B's~~] submitted an application for Medicare supplement coverage. Individual B has three months of creditable coverage. Under this example, the issuer of a Medicare supplement policy must give Individual B a three-month credit against any preexisting condition exclusion period.

(3) Individual C— [~~:~~] Subject to a six-month [~~six month~~] preexisting condition exclusion period. Relevant creditable coverage history: Individual C is covered under an individual health insurance policy for one month beginning May 1, 1998, through May 31, 1998, followed by a gap in coverage of 61 days from June 1, 1998, through July 31, 1998. On August 1, 1998, Individual C is covered under an association health plan for two months through September 30, 1998, followed by a gap in coverage of 64 days or until November 4, 1998, on which date Individual C submitted an application for Medicare supplement coverage. Individual C has a gap in coverage of greater than 63 days. As a result, under this example, the Medicare supplement issuer can fully apply the preexisting condition exclusion provision to Individual C.

(f) Invitation to contract advertisements, as defined in §21.113(b) of this title (relating to Rules Pertaining Specifically to Accident and Health Insurance Advertising and Health Maintenance Organization Advertising), must [~~shall~~] include the following statement: "Benefits and premiums under this policy may be suspended for up to 24 months if you become entitled to benefits under Medicaid. You must request that your policy be suspended within 90 days of becoming entitled to Medicaid. If you lose (are no longer entitled to) benefits from Medicaid, this policy can be reinstated if you request reinstatement within 90 days of the loss of such benefits and pay the required premium."

§3.3325. Medicare Select Policies, Certificate, and Plans of Operations.

(a) This section applies [~~shall apply~~] to Medicare Select policies, certificates, and plans of operation, as defined in this section.

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

(c) The following words and terms, when used in this section, [~~shall~~] have the following meanings, unless the context indicates otherwise. These words and terms must [~~shall~~] be defined and included in all Medicare Select policies, certificates, and plans of operation.

(1) Complaint--Any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) Emergency care [~~Care~~]--Bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the patient's health in serious jeopardy;

(B) serious impairment to bodily functions; or

(C) serious dysfunction of any bodily organ or part.

(3) Grievance--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.

(4) Medicare Select issuer [~~Issuer~~]--An issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(5) Medicare Select policy [~~Policy~~] or Medicare Select certificate [~~Certificate~~]--A Medicare supplement policy or certificate, respectively that contains restricted network provisions.

(6) Network provider [~~Provider~~]--A provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits covered under a Medicare Select policy.

(7) Nonnetwork provider [~~Non-network Provider~~]--A provider of health care, or a group of providers of health care, that has not entered into a written agreement with the issuer to provide benefits covered under a Medicare Select policy.

(8) Restricted network provisions [~~Network Provisions~~]--Any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(9) Service area [~~Area~~]--The geographic area approved by the commissioner as part of the plan of operation or amended plan of operation, within which an issuer is authorized to offer a Medicare Select policy.

(d) The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, under [~~pursuant to~~] this section and the Omnibus Budget Reconciliation Act (OBRA) of 1990, §4358, if the commissioner finds that the issuer has satisfied all of the requirements of this subchapter.

(e) A Medicare Select issuer may [~~shall~~] not issue a Medicare Select policy or certificate in this state until the commissioner approves its plan of operation [~~has been approved by the commissioner~~]. A Medicare Select issuer may not file a Medicare Select policy under [~~the~~] Insurance Code Chapter 1701, Subchapter B [~~, Article 3.42(c)~~], until the commissioner has approved its plan of operation [~~has been approved by the commissioner~~].

(f) A Medicare Select issuer must [~~shall~~] file a proposed plan of operation with the department [~~Department~~], the form and content of which is [~~shall be~~] subject to approval by the commissioner. The plan of operation must [~~shall~~] contain, at a minimum, the information in paragraphs (1) - (7) of this subsection, and at the time of submission must [~~shall~~] have a form number printed or typed on the lower left hand corner of the face page.

(1) The plan must contain evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration of each of the items referenced in subparagraphs (A) - (E) of this paragraph.

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

(B) The number of network providers in the service area must be documented by credible statistics to be 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) Written agreements with network providers describing specific responsibilities must be included.

(D) Emergency care availability 24 hours per day and seven days a week must be demonstrated.

(E) In the case of covered services [~~that are~~] subject to a restricted-network [~~restricted network~~] provision and that 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 covered under a Medicare Select policy or certificate. This subparagraph does [~~shall~~] not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) A clear description of the service area must be provided by narrative statement or [~~and/or~~] a map.

(3) The grievance procedure used [~~to be utilized~~] must be described.

(4) The quality assurance program must be described, 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) Network providers must be listed and described[~~,~~] by specialty.

(6) Copies of the written information proposed to be used by the issuer to comply with subsection (k) of this section must be provided.

(7) Any other information requested by the commissioner must be provided.

(g) A Medicare Select issuer must [~~shall~~] file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner 60 days before [~~prior to~~] implementing the [~~such~~] changes. Changes will [~~Such changes shall~~] be considered approved by the commissioner after 30 days unless specifically disapproved or unless the issuer requests an extension of the 30-day period and the commissioner grants the requested extension.

(h) An updated list of network providers must [~~shall~~] be filed with the commissioner at least quarterly. If there is no change to the list of network providers within a particular calendar quarter, correspondence indicating no change from the prior reporting period to the current reporting period must, at a minimum, be filed to meet the reporting requirements of this subchapter.

(i) A Medicare Select policy or certificate may [~~shall~~] not restrict payment for covered services provided by nonnetwork [~~non-network~~] providers if:

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

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

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

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

(1) an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with other Medicare supplement policies or certificates offered by the issuer and with other Medicare Select policies or certificates;

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

(3) a description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized (except to

the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L);

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

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

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

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

(8) For hospital network providers, the statement in 12-point bold-face type: "Only certain hospitals are network providers under this policy. Check with your physician to determine if he or she has admitting privileges at the network hospital. If he or she does not, you may be required to use another physician at time of hospitalization or you will be required to pay for all expenses." This statement must [~~shall~~] also be included in the "invitation to contract" advertisement, as that term is defined in §21.113(b) of this title (relating to Rules Pertaining Specifically to Accident and Health Insurance Advertising and Health Maintenance Organization Advertising).

(l) Before [~~Prior to~~] the sale of a Medicare Select policy or certificate, a Medicare Select issuer must [~~shall~~] obtain from the applicant a signed and dated form stating that the applicant has received the information provided under [~~pursuant to~~] subsection (k) of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

(m) A Medicare Select issuer must [~~shall~~] have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures must [~~shall~~] be aimed at mutual agreement for settlement and may include arbitration procedures. If a binding arbitration procedure is included, the insured must have made an informed choice to accept binding arbitration after having been advised of the right to reject this method of dispute or claim resolution.

(1) The grievance procedure must [~~shall~~] be described in the policy and certificates and in the outline of coverage. The in-hospital grievance procedure must [~~shall~~] be outlined separately from the grievance procedures for other treatments or [~~and/or~~] services, or both. All grievances should be addressed immediately and resolved as soon as possible. Grievances relating

to ongoing hospital treatment should be addressed immediately on receipt of any written or oral grievance, and be resolved as quickly as possible in a manner that [~~which~~] does not interfere with, obstruct, or interrupt continued proper medical treatment and care of the patient. The timetable for their resolution must [~~shall~~] comply with all applicable provisions of the Insurance Code.

(2) At the time the policy or certificate is issued, the issuer must [~~shall~~] provide detailed information to the policyholder describing how a grievance may be registered with the issuer, both during the period of care and after care.

(3) Grievances must [~~shall~~] be considered in a timely manner and must [~~shall~~] be transmitted to appropriate decision makers [~~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 must [~~shall~~] be taken promptly.

(5) All concerned parties must [~~shall~~] be notified about the results of a grievance.

(6) The issuer must [~~shall~~] report no later than each March 31st to the commissioner regarding its grievance procedure. The report must [~~shall~~] be in a format prescribed by the commissioner, [~~and~~] must [~~shall~~] contain the number of grievances filed in the past year, and must include a summary of the subject, nature, and resolution of the [~~such~~] grievances.

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

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

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

(q) Medicare Select policies and certificates must [~~shall~~] provide for continuation of coverage in the event the Secretary [~~secretary of health and human services~~] determines that Medicare Select policies and certificates issued under [~~pursuant to~~] this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer must [~~shall~~] make available to each individual covered under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer that [~~which~~] has comparable or lesser benefits and that [~~which~~] does not contain a restricted network provision. The issuer must [~~shall~~] make these [~~such~~] policies and certificates available without requiring evidence of insurability.

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

(r) A Medicare Select issuer must [~~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.

Repeal of 28 TAC §3.3318

STATUTORY AUTHORITY. The repeal of §3.3318 is proposed under Insurance Code §§1652.005, 1652.051, 1652.052, 1652.102, 1652.151, 1652.152, and 36.001; and 42 U.S.C. §1395ss.

Insurance Code §1652.005 provides that, in addition to other rules required or authorized by this chapter, the commissioner must adopt reasonable rules necessary and proper to carry out Chapter 1652, including rules adopted in accordance with federal law relating to the regulation of Medicare supplement benefit plan coverage that are necessary for this state to obtain or retain certification as a state with an approved program.

Insurance Code §1652.051 provides, in part, that the commissioner must adopt reasonable rules to establish specific standards for provisions in Medicare supplement benefit plans and

standards for facilitating comparisons of different Medicare supplement benefit plans. The standards are in addition to and must be in accordance with applicable laws of this state; applicable federal law, rules, regulations, and standards; and any model rules and regulations required by federal law, including 42 U.S.C. §1395ss. The standards may include provisions relating to terms of renewability; benefit limitations, exceptions, and reductions; and exclusions required by state or federal law.

Insurance Code §1652.052(a) provides that the commissioner must adopt reasonable rules to establish minimum standards for benefits and claim payments under Medicare supplement benefit plans. Insurance Code §1652.052(b) states that the standards for benefits and claim payments must include the requirements for certification of Medicare supplement benefit plans under 42 U.S.C. §1395ss.

Insurance Code §1652.151 provides, in part, that the rules adopted under §1652.152 must include provisions and requirements that are at least equal to those required by federal law, including the rules, regulations, and standards adopted under 42 U.S.C. §1395ss.

Insurance Code §1652.152(a) provides that for full and fair disclosure in the sale of Medicare supplement benefit plans, a Medicare supplement benefit plan or certificate may not be delivered or issued for delivery in Texas unless an outline of coverage that complies with §1652.152 is delivered to the applicant when the applicant applies for the coverage, and Insurance Code §1652.152(b) provides that the commissioner by rule must prescribe the format and content of the outline of coverage required by subsection (a). The rules must address the style, arrangement, and overall appearance of the outline of coverage, including the size, color, and prominence of type and the arrangement of text and captions.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of Texas.

Title 42 U.S.C. §1395ss(a)(2)(A) provides, in part, that no Medicare supplemental policy may be issued in a state on or after the date specified, unless the State's regulatory program provides for the application and enforcement of the NAIC Model Standards and requirements.

CROSS REFERENCE TO STATUTE. The repeal of §3.3318 affects Insurance Code §§1652.005, 1652.051, 1652.052, 1652.102, 1652.151, 1652.152, and 36.001; and 42 U.S.C. §1395ss.

SUBCHAPTER T. Minimum Standards for Medicare Supplement Policies

§3.3318. Effective Date of Amendments; Impact on Existing Policies.

CERTIFICATION. This agency certifies that legal counsel has reviewed the proposal and found it to be within the agency's authority to adopt.

Issued at Austin, Texas, on December 5, 2017.

Norma Garcia
General Counsel
Texas Department of Insurance