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 Commissioner of Insurance adopts amendments to 28 Texas Administrative Code §§3.3302 – 3.3308, 3.3312, 3.3316, 3.3317, and 3.3323 – 3.3325, and also adopts the repeal of 28 TAC §3.3318, relating to Medicare supplement policies. These amendments and repeal 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). Sections 3.3302 – 3.3305, 3.3312, 3.3316, 3.3317, and the repeal of 28 TAC §3.3318 are adopted without change to the text as proposed in the December 22, 2017, issue of the *Texas Register* (42 TexReg 7259). Sections 3.3306 – 3.3308 and 3.3323 – 3.3325, are adopted with nonsubstantive changes to the text as proposed, as described in the following paragraphs.

The department changed §3.3306(b) and (c) to capitalize "Standardized" and it changed §3.3306(b)(3)(A) to make "deductible" lowercase for consistency with the department's writing style.

The department changed §3.3306(b)(1)(A)(ii) and §3.3325(c)(8) to replace "which" with "that" for consistency with the department's current writing style. The department also changed the word "subchapter" to "title" in §3.3306(b)(1)(A)(iii) for consistency with the department's writing style.

The department changed 28 TAC §3.3306(c)(5)(F)(ii) to delete the 2017 Plan F high deductible amount of $2,200 and replace it with the 2018 Plan F high deductible amount of $2,240. The department also changed 28 TAC §3.3306(c)(5)(H)(ii) to delete the 2017 Plan G high deductible amount of $2,200 and replace it with the 2018 Plan G high deductible amount of $2,240. The department changed 28 TAC §3.3306(c)(5)(I)(x) to delete the 2017 Plan K out-of-pocket limit of $5,120 and replace it with the 2018 Plan K out-of-pocket limit of $5,240. The department changed 28 TAC §3.3306(c)(5)(J)(iii) to delete the references to 2017 Plan L and Plan K out-of-pocket limits of $2,560 and $5,120 and replace them with the 2018 Plan L and Plan K out-of-pocket limits of $2,620 and $5,240. These changes to 28 TAC §3.3306 are necessary to reflect the dollar amounts to be paid by Medicare, the plan, and the covered person for the 2018 calendar year.

The department changed §§3.3306(c)(6), 3.3307(g), 3.3307(g)(1)(C), 3.3308(c)(2)(E), 3.3323, 3.3325(c)(9), 3.3325(d) – (f), 3.3325(f)(7), 3.3325(g) and (h), and 3.3325(m)(6) and Figure 3.3308(c)(2)(E) to capitalize "Commissioner" for consistency with the department's current writing style.

The department changed §3.3307(d)(2)(B) – (D) to correct punctuation by removing periods that appeared in error.

The department changed 28 TAC §3.3308(c)(2)(E) to delete the reference to LHL 050 Rev. 12/17 and replace it with a reference to LHL 050 Rev. 06/18. This change is necessary because TDI has updated the contents of the form to show the dollar amounts to be paid by Medicare, the plan, and the covered person for the 2018 calendar year.

The department also changed Figure §3.3308(c)(2)(E) to correct nonsubstantive formatting and grammatical errors, including consistent use of hyphens within the term "out-of-pocket" and ensuring consistent capitalization of certain terms, such as "Plan F." The department revised the font size to size 12 throughout the Figure, which is necessary to conform to the requirements of §3.3308(c). This change necessitated additional page breaks, which the department combined with modification of paragraph and table spacing to improve readability. In addition, the department changed symbols and asterisks used within the *PLAN K* and *PLAN L* charts to more closely align with the NAIC model.

The department changed §3.3324(e)(1), (2), and (3) to insert spaces, for consistency with the department's current writing style.

The department changed §§3.3306(c)(1)(B), 3.3306(c)(5)(H), and 3.3308(c)(2)(E); and Figure §3.3308(c)(2)(E) in response to public comments, as described in the following paragraphs.

The department changed §3.3306(c)(1)(B) by moving the proposed phrase in §3.3306(c)(1)(B)(ii), "who first became eligible for Medicare before January 1, 2020," to the main body of the text in §3.3306(c)(1)(B) to clarify that the requirement as provided in §3.3306(c)(1)(B) applies to both Plans C and F.

The department changed §3.3306(c)(5)(H) by revising the language to clarify that the Part B deductible is not an expense that would ordinarily be paid by Plan G. The department added language to clarify that the Standardized Medicare supplement Plan G with High Deductible must include 100 percent of the covered expenses following payment of the annual deductible set forth in §3.3306(c)(5)(H)(ii), but that it will not provide coverage for any portion of the Medicare Part B deductible. The language further

states that the Medicare Part B deductible paid by a beneficiary will be considered an out-of-pocket expense in meeting the annual high cost deductible.

The department changed §3.3308(c)(2)(E) to require use of the revised outline of coverage form no later than July 1, 2019.

The department changed Figure §3.3308(c)(2)(E), revising the column heading in the *Benefit Chart of Medicare Supplement Plans Sold on or after June 1, 2020,* for Plans C and F to say "Medicare first eligible before 2020 only." The department also removed the checkmark for "skilled nursing facility coinsurance" in Plans A and B, because these plans do not provide this benefit. Additionally, the department removed the checkmark for the Medicare A deductible, because Plan A does not provide this benefit.

The department also replaced language that appears in the summary portion about *Plan G or High Deductible Plan G* for Part A and Part B with the wording used in the NAIC Model. As adopted, the language states that "out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible."

The department also changed the *PLAN G or HIGH DEDUCTIBLE Plan* G chart to make the column headings for home health care and foreign travel consistent with other benefits for Plan G. As adopted, they say "MEDICARE PAYS, [AFTER YOU PAY $[2,240] DEDUCTIBLE, **] PLAN PAYS, and [IN ADDITION TO [2,240] DEDUCTIBLE, **] YOU PAY."

REASONED JUSTIFICATION. 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 Texas 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 Texas; 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, 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.

Individuals issued a certificate in Texas 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, amendments to 28 TAC §3.3306(b)(1)(E), relating to 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 Texas, 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 amendments to 28 TAC §3.3307(f), relating to refund or credit calculations, are necessary for both efficiency and consistency in reporting the required data.

A description of adopted changes to specific sections follows. Except for where the discussion notes that a change was made to the text as proposed, all the described changes were included as part of the proposed text.

Section 3.3302. The adoption updates a statutory citation. The adoption also adds subsection (b), derived from repealed 28 TAC §3.3318. Adopting these provisions in §3.3302 is more consistent with the subject matter of the applicability and scope of Insurance Code Chapter 1652. New §3.3302(b) 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 adoption adds a new definition to §3.3303 for a "2020 newly eligible individual" for consistency with how such an individual is defined under MACRA, 42 U.S.C. §1395ss(z)(2), and renumbers the remaining definitions as appropriate to reflect the addition of the new definition. The adoption also updates statutory citations in new paragraph (20) to reflect the nonsubstantive recodification of the Insurance Code.

Section 3.3304. The adoption updates Administrative Code citations in paragraph (11) to be consistent with §3.3306 as adopted.

Section 3.3305. The adoption updates Administrative Code citations in subsections (a) and (d) to be consistent with §3.3306 as adopted.

Section 3.3306. The adoption 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 adoption adds a new subsection (a) and redesignates the subsections that follow it to reflect this change. The following descriptions address the redesignated subsections, unless stated otherwise.

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 adoption 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 adoption states that standardized Medicare supplement plans C, F, and High Deductible F may not be offered to 2020 newly eligible individuals.

The adoption 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 adoption makes a correction to a citation in subsection (b)(1)(E)(iii) by changing "(iv)" to "(v)." This amendment is necessary because the previous was inconsistent with the citation reference in the NAIC Model Rule. The adoption 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 Texas 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 adoption adds the words "G with High Deductible" in subsection (b)(2) and clarifies that (c)(1)(B) applies to each prospective policyholder and certificate holder who first became eligible for Medicare before January 1, 2020. The adoption 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 adoption deletes previous 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 adopted §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 new outline of coverage, the adoption updates deductible and out-of-pocket limit amounts to reflect the 2018 coverage levels, as published by Centers for Medicare & Medicaid Services. The adoption also updates Administrative Code citations to reflect the adopted redesignations within the section.

Section 3.3307. The adoption 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 adoption also replaces the previous Figure: 28 TAC §3.3307(f) with 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 adoption also updates the statutory citation in subsection (g) to reflect the nonsubstantive recodification of the Insurance Code.

Section 3.3308. The adoption 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 adoption amends subsection (c)(2)(E), relating to the Outline of Coverage form, Form No. LHL 050 Rev. 06/09, applicable to policies with an effective date for coverage of June 1, 2010, or later. The adoption also repeals LHL 050 Rev. 06/09 and creates an updated version of the form titled "LHL 050 Rev. 06/18."

New LHL 050 Rev. 06/18 includes disclosure provisions (provisions that were inadvertently excluded from LHL 050 Rev. 06/09) to address limitations and exclusions, refund of premium, and grievance procedures, which are consistent with subsections (c)(2)(B) – (D). The adopted form also reflects 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.

As proposed, the adoption makes nonsubstantive editorial and formatting changes to conform to the agency's current style and to improve the rule's clarity. The adoption also updates an Administrative Code citation at subsection (a)(4)(C) to reflect §3.3306 as adopted. 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. 06/18, adopted §3.3308(c)(2)(E) indicates that issuers are not required to begin using the new form until July 1, 2019.

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

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

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

Section 3.3318. The adoption repeals current §3.3318. Amendments to §3.3302(b) incorporate provisions similar to some of the provisions repealed in §3.3318, as previously described.

Section 3.3323. The adoption 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 adoption deletes outdated language about enrollment before 1997. The adoption also updates an Administrative Code citation in subsection (d), consistent with adopted §3.3306.

The Commissioner also adopts the proposed amendments to 28 TAC §§3.3302 – 3.3308, 3.3312, 3.3316, 3.3317, and 3.3323 – 3.3325 to update outdated contact information and administrative and statutory citations, and to make other nonsubstantive editorial and formatting changes for consistency with current agency style.

This adoption 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 adopted 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 Texas to retain certification as a state with an approved regulatory program for Medicare supplement insurance.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: The department received one written set of comments and no oral comments. UnitedHealthcare is in support of the proposal with changes. The department did not receive comments against the proposal.

Comment on §3.3306(b)(1)(E)(vi). The commenter supports adding §3.3306(b)(1)(E)(vi) to allow group Medicare supplement certificates to be replaced for Texas residents who move to another state.

Agency Response to Comment on §3.3306(b)(1)(E)(vi). The department appreciates the supportive comment.

Comment on §3.3306(c)(1)(B). The commenter suggests moving the proposed phrase in §3.3306(c)(1)(B)(ii) that states, "who first became eligible for Medicare before January 1, 2020," to the main body of the text in §3.3306(c)(1)(B) to clarify that the requirement as provided in §3.3306(c)(1)(B) applies to both Plans C and F.

Agency Response to Comment on §3.3306(c)(1)(B). The department agrees and has made the suggested change.

Comment on §3.3306(c)(5)(H). The commenter states that the Part B deductible is not an expense that would ordinarily be paid by Plan G, and because of this the commenter recommends adding language from Section 9.2(A)(4) of the NAIC Model to §3.3306(c)(5)(H) to read: "Plan G With High Deductible shall provide the benefits contained in subsection §3.3306(c)(5)(F) but shall not provide coverage for 100% or any portion of the Medicare Part B deductible; provided further, that the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible."

Agency Response to Comment on §3.3306(c)(5)(H). The department agrees with changing the language to clarify that the Part B deductible is not an expense that would ordinarily be paid by Plan G. However, the department does not agree with all of the suggested language. The department added language to make the following clarification by stating: "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, but will not provide coverage for any portion of the Medicare Part B deductible. The Medicare Part B deductible paid by the beneficiary will be considered an out-of-pocket expense in meeting the annual high cost deductible."

Comment on §3.3308(c)(2)(E). The commenter states that proposed §3.3308(c)(2)(E) requires insurers to use the December 2017 revision of the outline of coverage form no later than July 1, 2018. The commenter suggests a July 1, 2019, effective date to use the new outline of coverage form to more closely align with the January 1, 2020, plan changes.

Agency Response to Comment on §3.3308(c)(2)(E). The department agrees that use of the revised outline of coverage form should be more closely aligned with the January 1, 2020, plan changes. The department has changed §3.3308(c)(2)(E) to require use of the revised outline of coverage form to no later than July 1, 2019.

Comments on Figure §3.3308(c)(2)(E). The commenter suggests changes in the *Benefit Chart of Medicare Supplement Plans Sold on or after June 1, 2020.* The commenter states that the column heading for Plans C and F omitted the word "only" and should instead read "Medicare first eligible before 2020 only."

Agency Response to Comment on Figure §3.3308(c)(2)(E). The department agrees and has made the change.

Comments on Figure §3.3308(c)(2)(E). The commenter suggests additional changes in the *Benefit Chart of Medicare Supplement Plans Sold on or after June 1, 2020.* The commenter states that Plans A and B should not have a checkmark for skilled nursing facility coinsurance, as these plans do not provide this benefit. The commenter states that Plan A should not have a checkmark for the Medicare A deductible because Plan A does not provide this benefit.

Agency Response to Comment on Figure §3.3308(c)(2)(E). The department agrees and has made the changes.

Comments on Figure §3.3308(c)(2)(E). The commenter suggests replacing language that appears in the summary portion about Plan G or High Deductible Plan G for Part A and Part B with the wording used in the NAIC Model, because the Part B deductible is not an expense that would ordinarily be paid by Plan G.

Agency Response to Comment on Figure §3.3308(c)(2)(E). The department agrees and has made the changes. The language now states that "out-of-pocket expenses for this deductible include expenses for

the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible."

Comments on Figure §3.3308(c)(2)(E). The commenter suggests changes in the *PLAN G or HIGH DEDUCTIBLE Plan* G chart. The commenter states that the column headings for home health care and foreign travel should be consistent with other benefits for Plan G and read "MEDICARE PAYS, [AFTER YOU PAY $[2,240] DEDUCTIBLE, **] PLAN PAYS, and [IN ADDITION TO [2,240] DEDUCTIBLE, **] YOU PAY.

Agency Response to Comment on Figure §3.3308(c)(2)(E). The department agrees and has made the changes.

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

STATUTORY AUTHORITY. The Commissioner adopts the amendments to 28 TAC §§3.3302 – 3.3308, 3.3312, 3.3316, 3.3317, and 3.3323 – 3.3325 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 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 Texas 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 Texas; 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. 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.

TEXT.

§3.3302. Applicability and Scope.

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

(1) all Medicare supplement policies as defined in Insurance Code §1652.002 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, 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 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) 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) 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.

(6) 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) 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) Creditable coverage--Any coverage of an individual as defined in §21.1101 of this title (relating to Definitions).

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

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

(11) Insolvency--The situation that 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) 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) Medicaid--Grants to States for Medical Assistance Programs, Title XIX of the Social Security Act Amendments of 1965 as then constituted or later amended.

(14) Medicare--The Health Insurance for the Aged Act, Title XVIII of the Social Security Act Amendments of 1965 as then constituted or later amended.

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

(16) 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 provide health services, including but not limited to HMO plans (with or without a 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) Medicare Advantage private fee-for-service plan--An entity as defined in 42 U.S.C. §1395w-28(b)(2).

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

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

(20) 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 Insurance Code Chapter 842 (concerning Group Hospital Service Corporations), or, to the extent required by federal law, an evidence of coverage issued by an HMO subject to Insurance Code Chapter 843 (concerning Health Maintenance Organizations), for which a policy, subscriber contract, or 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 Insurance Code Chapter 842, or group evidence of coverage issued by an HMO subject to Insurance Code Chapter 843, 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 a contract in accordance with the Federal Social Security Act, §1876 (42 U.S.C. §§1395, et seq.) by an HMO subject to Insurance Code Chapter 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 an agreement under §1833(a)(1)(A) of the Federal Social Security Act (42 U.S.C. §§1395, et seq.)

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

(22) 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 March 1, 1992.

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

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

(25) 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 policy, subscriber contract, certificate, or evidence of coverage contains definitions or terms that conform to the requirements of this section.

(1) "Accident" or "Accidental Injury" or "Accidental Means" must be defined to employ "result" language and may not include words that 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 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 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 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 (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 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" or "Title I, Part I of Public Law 89-97, as 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."

(7) "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 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 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.

(10) "Physician" may 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 applicable laws.

(11) "Sickness" may not be defined to be more restrictive than the following: "Sickness means illness or disease of a covered person that 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 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 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 contain benefits that 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 January 1, 2006, must 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 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) 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 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. 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 June 1, 2010, remain subject to the laws and rules in effect when the policy or certificate was delivered or issued for delivery. These are minimum standards and do not prevent the inclusion of other provisions or benefits that 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, Insurance Code Chapter 1652, and any other applicable law.

(A) A Medicare supplement policy or certificate must 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 waive any time applicable to preexisting condition waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy or certificate to the extent the time was spent under the original policy.

(ii) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate that has been in effect for at least six months, the replacing policy or certificate must 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 (relating to Guaranteed Issue for Eligible Persons) or §3.3324(a) of this title (relating to Open Enrollment), the issuer must reduce the period of any preexisting condition exclusion as required by §3.3312(a)(2) of this title and §3.3324(c) and (d) of this title.

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

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

(D) A Medicare supplement policy or certificate may not:

(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 or nonrenewed by the insurer solely on the grounds of deterioration of health.

(E) Each Medicare supplement policy must be guaranteed renewable and must comply with the provisions of clauses (i) – (vi) of this subparagraph.

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

(ii) The issuer may 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) of this subparagraph, the issuer must offer certificate holders an individual Medicare supplement policy that, 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:

(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 offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy may not result in any exclusion for 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 be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned on 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 comply with clauses (i) – (iv) of this subparagraph:

(i) A Medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate will 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 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 provide that benefits and premiums under the policy will 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 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 comply with subclauses (I) – (III) of this clause.

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

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

(III) Reinstitution of coverage must 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 to Medicare 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 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 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 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 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 hospice care and respite care expenses.

(3) Standards for additional benefits. The following additional benefits must 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) 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: 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 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

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

(E) Medically 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 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 care needed immediately because of an injury or an illness of sudden and unexpected onset.

(c) 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 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.

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

(A) An issuer must 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)(2) of this section.

(B) If an issuer makes available any of the additional benefits described in subsection (b)(3) of this section, or offers standardized benefit Plans K or L (as described in paragraph (5)(I) and (J) of this subsection), then the issuer must make available to each prospective policyholder and certificate holder who first became eligible for Medicare before January 1, 2020, 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).

(2) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this subsection may 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 (relating to Medicare Select Policies, Certificates, and Plans of Operation).

(3) Benefit plans must 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 (relating to Definitions). Each benefit plan must be structured in accordance with the format provided in

subsection (b)(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) or (J) 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) of this paragraph.

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

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

(C) Standardized Medicare supplement benefit Plan C must include only the following: 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 deductible, and medically necessary emergency care in a foreign country as defined in subsection (b)(3)(A)(i), (B), (C), and (E) of this section, respectively.

(D) Standardized Medicare supplement benefit Plan D must include only: 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, and medically necessary emergency care in a foreign country as defined in subsection (b)(3)(A)(i), (B), and (E) of this section, respectively.

(E) Standardized Medicare supplement (regular) Plan F must include only the following: The basic (core) benefits as defined in subsection (b)(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)(3)(A)(i), (B), (C), (D), and (E) of this section, respectively.

(F) Standardized Medicare supplement Plan F with High Deductible must 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)(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)(3)(A)(i), (B), (C), (D), and (E) of this section, respectively.

(ii) The annual deductible in Plan F with High Deductible must consist of out-of-pocket expenses, other than premiums, for services covered by regular Plan F, and must be in addition to any other specific benefit deductibles. The basis for the deductible is $2,240 for 2018, 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.

(G) Standardized Medicare supplement benefit Plan G must include only the following: 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. 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, but will not provide coverage for any portion of the Medicare Part B deductible. The Medicare Part B deductible paid by the beneficiary will be considered an out-of-pocket expense in meeting the annual high cost deductible.

(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 $2,240 for 2018, 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) Standardized Medicare supplement Plan K must include only the following:

(i) Part A 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, 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 150 days: On 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 rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must 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 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: 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 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 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: 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: 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: 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 $5,240 in 2018, indexed each year by the appropriate inflation adjustment specified by the Secretary.

(J) Standardized Medicare supplement Plan L must include only the following:

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

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

(iii) the benefit described in subparagraph (I)(x) of this subsection, but substituting $2,620 for $5,240.

(K) Standardized Medicare supplement Plan M must include only the following: The basic (core) benefit as defined in subsection (b)(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)(3)(A)(ii), (B), and (E) of this section, respectively.

(L) Standardized Medicare supplement Plan N must include only the following: The basic (core) benefit as defined in subsection (b)(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)(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 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 include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits may not include an outpatient prescription drug benefit. New or innovative benefits may not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

§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 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 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 of the aggregate amount of premiums earned in the case of group policies; or

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

(b) HMO loss ratio standard. An HMO loss ratio, where coverage is provided on a service rather than reimbursement basis, must 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 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 experience loss ratio standard. For the most recent calendar year, the ratio of incurred losses to earned premiums for all policies or certificates that have been in force for three years or more, as of December 31st of the most recent year, must be equal to or greater than:

(1) at least 75 percent in the case of group policies; and

(2) at least 65 percent in the case of individual policies.

(d) Filing of rates and rating schedules. All filings of rates and rating schedules must demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions must 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 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 be combined. But 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 combined, a rate revision request must not differentiate between the experience of the individual forms. Where significant inconsistencies between rate levels exist among forms providing similar benefits, some deviation in rate revision must be allowed to reduce the significant inconsistencies.

(1) Each Medicare supplement policy or certificate form must be accompanied, on submission for approval, by an actuarial memorandum. The memorandum must be prepared and signed by a qualified actuary in accordance with generally accepted actuarial principles and practices, and must 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 (for individual coverage) or at least 75 percent (for group coverage), which 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 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 also provide an actuarial memorandum, prepared by a qualified actuary in accordance with generally accepted actuarial principles and practices, which must contain the following information:

(A) the form number addressed by the actuarial memorandum;

(B) a brief description of benefits provided;

(C) a schedule of rates before and after the rate change;

(D) a statement of the reason and basis for the rate change;

(E) a demonstration and certification by the qualified actuary 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 rate change and demonstration must 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 rate change and demonstration must 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 rate change and demonstration must 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 policies or certificates in force less than three years, a demonstration to show that the third-year loss ratio is expected to be equal to or greater than the applicable percentage; and

(G) a certification by the qualified actuary that the resulting premiums are reasonable in relation to the benefits provided.

(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 be given to the experience. If fewer than 500 policies are in force, then no credibility (0 percent) must be given to the experience. The principle of linear interpolation must be used for in force numbers between 500 and 2,000. For group policy forms, the reference in this paragraph to the number of in force policies means the number of 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 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 March 1, 1992, the expected claims in relation to premiums must meet:

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

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

(C) a loss ratio of at least 65 percent 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 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 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 also demonstrate, in accordance with actuarial standards of practice using reasonable assumptions, that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration must exclude active life reserves. An expected third-year loss ratio that is greater than or equal to the applicable percentage must be demonstrated for policies or certificates in force less than three years. The annual filing requirements in this subsection must 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 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 contained in Figure: 28 TAC §3.3307(f) of this section. 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 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 be excluded.

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

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

(g) Premium adjustments to conform with minimum standards for loss ratios. As soon as practicable, but before the effective date of enhancements to Medicare benefits, every issuer of Medicare supplement insurance policies, contracts, or coverage in this state must 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 premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or contracts. Documents necessary to justify the adjustment must accompany the filing.

(A) Every issuer of Medicare supplement insurance or benefits to a resident of this state under Insurance Code Chapter 1652 must make premium adjustments:

(i) necessary to produce an expected loss ratio under the policy or contract that 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 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 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 be filed. The riders, endorsements, or policy forms must 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 be maintained for each policy form with business in force in Texas, by calendar year of issue, and must be made available to the department.

§3.3308. Required Disclosure Provisions.

(a) General rules.

(1) Medicare supplement policies and certificates must include a renewal or continuation provision. The language or specifications of the renewal or continuation provision must be consistent with the type of contract issued. The provision must be appropriately captioned, appear on the first page of the policy, and 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 reduce or eliminate benefits or coverage in the policy must require signed acceptance by the policyholder. After the date of issue of the policy or certificate, any rider or endorsement that increases benefits or coverage with concomitant increase in premium during the policy term must 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 be set forth in the policy.

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

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

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

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

(C) the policy or certificate must include a provision explaining the reduction of the preexisting condition limitation for individuals who 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 Eligible Persons), or §3.3324(c) and (d) of this title (relating to Open Enrollment).

(5) Medicare supplement policies and certificates must have a notice prominently printed on the first page or attached to the first page stating in substance that the policyholder or certificate holder has 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 provide hospital or medical-expense coverage on an expense-incurred or indemnity basis, to persons eligible for Medicare must 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* incorporating the latest statutory changes is not available from a government agency, companies may comply with this provision by modifying the latest available *Guide* to the extent required by applicable law.

(C) Except as provided in this section, delivery of the *Guide* must be made whether or not any 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* must be made to the applicant at the time of application, and acknowledgment of receipt of the *Guide* must be obtained from the applicant by the issuer. Issuers must deliver the *Guide* to the applicant for a direct response Medicare supplement policy on 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 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 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 policies, must obtain an acknowledgment of receipt of the outline from the applicant.

(2) If a Medicare supplement policy or certificate is issued on a basis that 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 accompany the policy or certificate when it is delivered. The outline of coverage must 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 the requirements of subsection (b)(1) of this section, insurers must use a form that 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 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 be shown on the cover page, and the plans that are offered by the issuer must be prominently identified. Premium information for plans that are offered must be shown on the cover page or immediately following the cover page and must be prominently displayed. The premium

and mode must be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant must be illustrated.

(2) The items in subparagraphs (A) – (C) of this paragraph must 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 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, 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 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 the death of an insured or on the surrender of the policy or certificate. If the policy contains these provisions, a description of the provisions must be included.

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

(E) The Commissioner adopts the Outline of Coverage form, LHL 050 Rev. 06/18. This form 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. 06/18 no later than July 1, 2019.

Figure: 28 TAC §3.3308(c)(2)(E)

Figure: 28 TAC §3.3308(c)(2)(E)

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
* Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[2,240] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $[2,240]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.							Out-of-pocket limit $[5,240] paid at 100% after limit reached	Out-of-pocket limit $[2,620] paid at 100% after limit reached		

LHL 050 Rev. 06/18

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 only	
	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 [2018][2]					$[5,240][2]	$[2,620][2]				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $[2,240] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[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 $[1,340]	$0	$[1,340] (Part A deductible)
61st thru 90th day	All but $[335] a day	$[335] a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $[670] a day	$[670] a day	$0
- Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
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 $[167.50] a day	$0	Up to $[167.50] a day
101st day and after	$0	$0	All costs

PLAN A

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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

PLAN A

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 $[1,340]	$[1,340] (Part A deductible)	$0
61st thru 90th day	All but $[335] a day	$[335] a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $[670] a day	$[670] a day	$0
- Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
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 $[167.50] a day	$0	Up to $[167.50] a day
101st day and after	$0	$0	All costs

PLAN B

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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

PLAN B

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 $[1,340]	$[1,340] (Part A deductible)	$0
61st thru 90th day	All but $[335] a day	$[335] a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $[670] a day	$[670] a day	$0
- Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
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 $[167.50] a day	Up to $[167.50] a day	$0
101st day and after	$0	$0	All costs

PLAN C

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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

PLAN C

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

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 $[1,340]	$[1,340] (Part A deductible)	$0
61st thru 90th day	All but $[335] a day	$[335] a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $[670] a day	$[670] a day	$0
- Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
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 $[167.50] a day	Up to $[167.50] a day	$0
101st day and after	$0	$0	All costs

PLAN D

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
- First $[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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

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

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,240] DEDUCTIBLE,**] YOU PAY
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 $[167.50] a day	Up to $[167.50] 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 F or HIGH DEDUCTIBLE PLAN F

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

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

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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,240] DEDUCTIBLE,**] YOU PAY
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 $[2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,240] 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 $[2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,240] 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 $[2,240] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $[2,240]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

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

PLAN G or HIGH DEDUCTIBLE PLAN G

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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,240] DEDUCTIBLE,**] YOU PAY
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 $[167.50] a day	Up to $[167.50] 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 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 $[2,240] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $[2,240]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,240] 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	[AFTER YOU PAY $[2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,240] 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	$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	[AFTER YOU PAY $[2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2,240] 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 K

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,340]	$[670] (50% of Part A deductible)	$[670] (50% of Part A deductible) ♦
61st thru 90th day	All but $[335] a day	$[335] a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $[670] a day	$[670] a day	$0
- Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0***
– Beyond the additional 365 days	$0	$0	All costs

PLAN K

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
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 $[167.50] a day	Up to $[83.75] a day (50% of Part A coinsurance)	Up to $[83.75] 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
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.

PLAN K

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $[5,240])
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 $[2,620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,340]	$[1,005] (75% of Part A deductible)	$[335] (25% of Part A deductible) ♦
61st thru 90th day	All but $[335] a day	$[335] a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $[670] a day	$[670] a day	$0
- Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0***
– Beyond the additional 365 days	$0	$0	All costs

PLAN L

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $[167.50] a day	Up to $[125.63] a day (75% of Part A coinsurance)	Up to $[41.87] 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
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.

PLAN L

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $[2,620])
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 $[1,340]	$[670] (50% of Part A deductible)	$[670] (50% of Part A deductible)
61st thru 90th day	All but $[335] a day	$[335] a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $[670] a day	$[670] a day	$0
- Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
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 $[167.50] a day	Up to $[167.50] a day	$0
101st day and after	$0	$0	All costs

PLAN M

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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

PLAN M

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

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 $[1,340]	$[1,340] (Part A deductible)	$0
61st thru 90th day	All but $[335] a day	$[335] a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $[670] a day	$[670] a day	$0
- Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
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 $[167.50] a day	Up to $[167.50] a day	$0
101st day and after	$0	$0	All costs

PLAN N

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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

PLAN N

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 the annual effective date of any Medicare benefit changes, every issuer providing Medicare supplement coverage to a resident of this state must notify its policyholders, contract holders, and certificate holders of modifications it has made to Medicare supplement insurance policies, contracts, or certificates. The notice must:

(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 be in outline form and in clear and simple terms so as to facilitate comprehension.

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

(4) Issuers must 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. 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 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, 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 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.

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

(A) Plan A, B, C, F (including F with a 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 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 (b)(5) of this section are entitled to the same Medicare supplement policy in which the individual was most recently enrolled, if available from the same issuer or, if not available, a policy described in paragraph (1) of this subsection. 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 (b)(6) of this section are entitled to 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 (b)(7) of this section are entitled to a Medicare supplement policy that has a benefit package classified as follows:

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

(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 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 termination or cessation); or

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

(2) 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 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 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 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 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.

(7) 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 Pool terminates and ends 63 days later.

(e) Extended Medicare supplement access for 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 Insurance Code Chapter 1652 must, for information purposes, file with the department's Life and Health Lines Office a copy of any master policy issued in connection with any certificate used in this state; all such certificates must 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 Insurance Code §1652.003 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 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 provide compensation to its agents and no agent may 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 be filed with the department 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 Insurance Code Chapter 544, 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 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 deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for a policy or certificate is submitted before 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 engage in a premium rating practice that results in higher premiums for any policy solely because the policy is issued under 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 be made available to all applicants without regard to age.

(b) The provisions of paragraphs (1) and (2) 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 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.

(c) If an applicant qualifies under subsection (a) of this section, is 65 years of age or older, and submits an application during the 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 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 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 (relating to Guaranteed Issue for Eligible Persons), and §3.3306(b)(1)(A) of this title (relating to Minimum Benefit Standards), subsection (a) of this section may 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 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 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 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 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 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, have the following meanings, unless the context indicates otherwise. These words and terms must 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--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--An issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(5) Medicare Select policy or Medicare Select certificate--A Medicare supplement policy or certificate, respectively that contains restricted network provisions.

(6) Network 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--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--Any provision that conditions the payment of benefits, in whole or in part, on the use of network providers.

(9) Service 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 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 not issue a Medicare Select policy or certificate in this state until the Commissioner approves its plan of operation. A Medicare Select issuer may not file a Medicare Select policy under Insurance Code Chapter 1701, Subchapter B, until the Commissioner has approved its plan of operation.

(f) A Medicare Select issuer must file a proposed plan of operation with the department, the form and content of which is subject to approval by the Commissioner. The plan of operation must contain, at

a minimum, the information in paragraphs (1) – (7) of this subsection, and at the time of submission must 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 reflect usual practice in the local area. Geographic availability must reflect the usual travel times within the community.

(B) The number of network providers in the service area 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 subject to a 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 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 a map.

(3) The grievance procedure used 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 file any proposed changes to the plan of operation, except for changes to the list of network providers, with the Commissioner 60 days before implementing the changes. Changes will 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 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 not restrict payment for covered services provided by nonnetwork 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 services through a network provider.

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

(k) A Medicare Select issuer must 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 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 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 the sale of a Medicare Select policy or certificate, a Medicare Select issuer must obtain from the applicant a signed and dated form stating that the applicant has received the information provided under 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 have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures must 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 be described in the policy and certificates and in the outline of coverage. The in-hospital grievance procedure must be outlined separately from the grievance

procedures for other treatments 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 does not interfere with, obstruct, or interrupt continued proper medical treatment and care of the patient. The timetable for their resolution must comply with all applicable provisions of the Insurance Code.

(2) At the time the policy or certificate is issued, the issuer must 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 be considered in a timely manner and must be transmitted to appropriate decision makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action must be taken promptly.

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

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

(n) At the time of initial purchase, a Medicare Select issuer must 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 make available to the individual covered the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer must 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 provide for continuation of coverage in the event the Secretary determines that Medicare Select policies and certificates issued under this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer must 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 has comparable or lesser benefits and that does not contain a restricted network provision. The issuer must make these 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 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 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 Commissioner adopts the repeal of 28 TAC §3.3318 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 §1652.102(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 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.

TEXT.

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 adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on May 24, 2018.

/s/ Norma Garcia
Norma Garcia
General Counsel
Texas Department of Insurance

The Commissioner adopts amendments to 28 Texas Administrative Code §§3.3302 – 3.3308, 3.3312, 3.3316, 3.3317, and 3.3323 – 3.3325 and also adopts the repeal of 28 TAC §3.3318.

/s/ Kent C. Sullivan
Kent C. Sullivan
Commissioner of Insurance

COMMISSIONER'S ORDER NO. **2018-5520**