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18.01.54 - MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

000. LEGAL AUTHORITY.
This rule is issued pursuant to the authority vested in the director under Chapters 2 and 44, Title 41, Idaho Code, and Chapter 52, Title 67, Idaho Code. (7-1-93)

001. TITLE AND SCOPE.

01. Purpose. The purpose of this rule is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of disability insurance coverages to persons eligible for Medicare. This rule superseded Rule No. 40 which became effective May 1, 1982. (7-1-93)

02. Applicability. Except as otherwise specifically provided in Section 012, 013, 014, 022, 023, 026 and 030, this rule shall apply to: (4-1-96)T

a. All Medicare supplement policies delivered or issued for delivery in this State on or after the effective date of this rule, and (4-1-96)T

b. All certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this State. (7-1-92)

03. Employers or Labor Organizations. This rule shall not apply to a policy or contract of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations. (7-1-92)

002. -- 003. (RESERVED).

004. DEFINITIONS.
For purposes of this rule: (7-1-92)

01. Applicant. "Applicant" means: (7-1-92)

a. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and; (4-1-96)T

b. In the case of a group Medicare supplement policy, the proposed certificateholder. (7-1-92)

02. Certificate. "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy. (7-1-92)

03. Certificate Form. "Certificate Form" means the form on which the certificate is delivered or issued for delivery by the issuer. (7-1-92)

04. Issuer. "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates. (7-1-92)

05. Medicare. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended. (7-1-92)

06. Medicare Supplement Policy. "Medicare Supplement Policy" means a group or individual policy of disability insurance or a subscriber contract of hospital and professional service corporations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et. seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1) which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. (4-1-96)T

07. Policy Form. "Policy Form" means the form on which the policy is delivered or issued for delivery by the issuer. (7-1-92)

005. POLICY DEFINITIONS AND TERMS.

No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms which conform to the requirements of this section. (4-1-96)T

01. Accident, Accidental Injury or Accidental Means. "Accident," "Accidental Injury," or "Accidental Means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. (7-1-92)

a. The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force." (7-1-92)

b. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law. (4-1-96)T

02. Benefit Period or Medicare Benefit Period. "Benefit Period" or "Medicare Benefit Period" shall not be defined more restrictively than as defined in the Medicare program. (7-1-92)

03. Convalescent Nursing Home, Extended Care Facility or Skilled Nursing Facility. "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall not be defined more restrictively than as defined in the Medicare program. (7-1-92)

04. Health Care Expenses. "Health Care Expenses" means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. Expenses shall not include: (4-1-96)T

a. Home office and overhead costs; (7-1-92)

b. Advertising costs; (7-1-92)

c. Commissions and other acquisition costs; (7-1-92)

d. Taxes: (7-1-92)

e. Capital costs; (7-1-92)

f. Administrative costs; and (7-1-92)

g. Claims processing costs. (7-1-92)

05. Hospital. "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. (7-1-93)

06. Medicare. "Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import. (7-1-92)

07. Medicare Eligible Expenses. "Medicare Eligible Expenses" shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare. (7-1-93)

08. Physician. "Physician" shall not be defined more restrictively than as defined in the Medicare program. (7-1-93)

09. Sickness. "Sickness" shall not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law. (7-1-92)

006. -- 010. (RESERVED).

011. POLICY PROVISIONS.

01. Prohibition Against Limitations or Exclusions More Restrictive Than Medicare. Except for permitted preexisting condition clauses as described in Subsection 013.01 and Subsection 016.01 of this rule, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare. (7-1-93)

02. Prohibition Against Waivers for Specifically Names or Described Preexisting Diseases. 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. (7-1-92)

03. Prohibition Against Policy Containing Benefits Which Duplicate Benefits Provided by Medicare. No Medicare Supplement policy or certificate in force in the State shall contain benefits which duplicate benefits provided by Medicare. (7-1-92)

012. MINIMUM BENEFIT STANDARDS FOR POLICIES OR CERTIFICATES ISSUED FOR DELIVERY PRIOR TO JULY 1, 1992.

No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards. (7-1-92)

013. GENERAL STANDARDS.

The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule. (7-1-92)

01. Preexisting Condition Exclusions. Idaho Code Sections 41-2106 and 41-4206 notwithstanding, a Medicare supplement policy shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage. (7-1-92)

02. Prohibition Against Differentiating Against Losses Resulting from Sickness Versus Accidents. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents. (7-1-92)

03. Benefits Designed to Cover Cost Sharing Amounts. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the factors. Premiums may be modified to correspond with such changes. (7-1-92)

04. Noncancelable, Guarantees Renewable, or Noncancelable and Guaranteed Renewable Medicare Supplement Policy. A "noncancelable," "guaranteed renewable," or "noncancelable and guaranteed renewable" Medicare supplement policy shall not: (7-1-92)

a. Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or (7-1-92)

b. Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health; and (7-1-92)

05. Cancelation, Termination or Replacement of Policy. (7-1-92)

a. Except as authorized by the Director of this state, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation. (7-1-92)

b. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Subsection 013.05.d., the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices: (7-1-92)

i. An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; or (7-1-92)

ii. An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Section 017. (7-1-92)

c. If membership in a group is terminated, the issuer shall: (7-1-92)

i. Offer the certificateholder the conversion opportunities described in Subsection 013.01; or (4-1-96)T

ii. At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy. (7-1-92)

d. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced. (4-1-96)T

06. Extension of Benefits Upon Termination. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. (7-1-93)

014. MINIMUM BENEFIT STANDARDS.

01. Coverage of Part A Expenses for Hospitalization from the 61st through the 90th Day. 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; (7-1-93)

02. Coverage of Part Inpatient Hospital Deductible. Coverage for either all or none of the Medicare

Part A inpatient hospital deductible amount; (7-1-92)

03. Coverage of Part A Expenses as Daily Hospital Charges. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days; (7-1-92)

04. Additional Coverage Upon Exhaustion of Medicare Hospital Inpatient Coverage. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days; (7-1-92)

05. Coverage Under Part A for Cost of First Three (3) Pints of Blood. Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulation) unless replaced in accordance with federal regulation or already paid for under Part B; (7-1-92)

06. Coverage for Coinsurance Amount Under Part B. Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket equal to the Medicare Part B deductible (7-1-92)

07. Coverage Under Part B for the Cost of First Three (3) Pints of Blood. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount. (7-1-92)

015. BENEFIT STANDARDS FOR POLICIES OR CERTIFICATES ISSUED OR DELIVERED ON OR AFTER JULY 1, 1992.

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this State on or after July 1, 1992. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. (7-1-92)

016. GENERAL STANDARDS.

The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule. (7-1-92)

01. Six (6) Month Limitation on Exclusions for Preexisting Conditions. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage. (7-1-92)

02. Losses Resulting from Sickness Versus Accident. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents. (7-1-92)

03. Benefits Designed to Cover Cost Sharing Amounts. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes. (7-1-92)

04. Termination of Coverage of a Spouse. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium. (7-1-92)

05. Cancelation, Nonrenewal, Replacement or Termination. Each Medicare supplement policy shall be guaranteed renewable. (4-1-96)T

a. The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and (7-1-92)

b. The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation. (7-1-92)

c. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Subsection 016.05.e., the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder (7-1-92)

i. Provides for continuation of the benefits contained in the group policy, or (7-1-92)

ii. Provides for benefits that otherwise meets the requirements of this Section. (4-1-96)T

d. If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall (7-1-92)

i. Offer the certificateholder the conversion opportunity described in Subsection 016.05.c., or (7-1-92)

ii. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy. (7-1-92)

e. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced. (4-1-96)T

06. Extension of Benefits Upon Termination. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. (7-1-92)

07. Suspension of Benefits and Premiums at the Request of the Policyholder or Certificateholder. (7-1-92)

a. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance. (4-1-96)T

b. If suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement. (4-1-96)T

c. Reinstitution of such coverages: (7-1-92)

i. Shall not provide for any waiting period with respect to treatment of preexisting conditions; (7-1-92)

ii. Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and (7-1-92)

iii. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended. (7-1-92)

017. STANDARDS FOR BASIC ("CORE") BENEFITS COMMON TO ALL BENEFIT PLANS.
Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other medicare Supplement Insurance Benefit Plans in addition to the basic "core" package, but not in lieu of it. (4-1-96)T\

01. Coverage Part A Expenses for Hospitalization from the 61st through the 90th Day. 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. (7-1-93)

02. Coverage of Part A Expenses for each Medicare Lifetime Inpatient Reserve Day Used. 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. (7-1-92)

03. Coverage of Part A Expenses Paid at DRG Day or Other Payment Standard. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. (7-1-92)

04. Coverage Under Parts A and B for the Cost of the First Three (3) Pints of Blood. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations. (7-1-92)

05. Coverage for Part B Coinsurance Amount. Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible. (7-1-92)

018. STANDARDS FOR ADDITIONAL BENEFITS.
The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 019 of this rule. (7-1-92)

01. Medicare Part A Deductible. Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period. (7-1-92)

02. 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 posthospital skilled nursing facility care eligible under Medicare Part A. (7-1-92)

03. Medicare Part B Deductible. Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement. (7-1-92)

04. Eighty (80%) Percent of the Medicare Part B Excess Charges. Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge. (7-1-92)

05. One Hundred Percent (100%) of the Medicare Part B Excess Charges. Coverage for all of the difference between the actual Medicare part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge. (7-1-92)

06. Basic Outpatient Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(7-1-92)

07. Extended Outpatient Prescription Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. (7-1-92)

08. Medically Necessary Emergency Care In a Foreign Country. Coverage to the extent not covered by Medicare for eight percent (80%) of the billed charges for Medicare for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset. (7-1-92)

09. Preventive Medical Care Benefit. Coverage for the following preventive health services: (7-1-92)

a. An annual clinical preventive medical history and physical examination that may include tests and services from Subsection 018.09.b. and patient education to address preventive health care measurers. (7-1-92)

b. Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate: (7-1-92)

i. Fecal occult blood test or digital rectal examination; (4-1-96)T

ii. Mammogram; (7-1-92)

iii. Dipstick urinalysis for hematuria, bacteriuria and proteinauria; (7-1-92)

iv. Pure tone (air only) hearing screening test, administered or ordered by a physician; (7-1-92)

v. Serum cholesterol screening (every five (5) years); (7-1-92)

vi. Thyroid function test; (7-1-92)

vii. Diabetes screening. (7-1-92)

c. Influenza vaccine administered at any appropriate time during the year and Tetanus and Diphtheria booster (every ten (10) years). (7-1-92)

d. Any other tests or preventive measures determined appropriate by the attending physician. (7-1-92)

e. Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare. (7-1-92)

10. At-Home Recovery Benefit. Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery. For purposes of this benefit, the following definitions shall apply: (7-1-92)

a. "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings. (7-1-92)

b. "Care provider" means a duly qualified or licensed home health aid or homemaker, personal care

aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry. (4-1-96)T

c. "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence. (7-1-92)

d. "At-home recovery visit" means the period of visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four (24) hour period of services provided by a care provider is one visit. (7-1-92)

e. Coverage Requirement and Limitations: (7-1-92)

i. At-home recovery services provided must be primarily services which assist in activities of daily living. (7-1-92)

ii. The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare. (7-1-92)

f. Coverage is limited to: (7-1-92)

i. No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment. (7-1-92)

ii. The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit. (7-1-92)

iii. One thousand six hundred dollars ($1,600) per calendar year. (7-1-92)

iv. Seven (7) visits in any one (1) week. (7-1-92)

v. Care furnished on a visiting basis in the insured's home. (7-1-92)

vi. Services provided by a care provider as defined in this section. (7-1-92)

vii. At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded. (7-1-92)

viii. At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit. (7-1-92)

g. Coverage is excluded for: (7-1-92)

i. Home care visits paid for by Medicare or other government programs; and (7-1-92)

ii. Care provided by family members, unpaid volunteers or providers who are not care providers. (7-1-92)

11. New or Innovative Benefits. New or Innovative Benefits: An issuer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement

policies. Drafting Note: The Omnibus Budget Reconciliation Act 1990, 42 U.S.C. Section 1395ss(p)(7), does not prohibit the issuers of Medicare supplement policies, through an arrangement with a vendor for discounts from the vendor, from making available discounts from the vendor to the policyholder or certificateholder for the purchase of items or services not covered under its Medicare supplement policies (for example: discounts on hearing aids or eyeglasses). Drafting Note: Use of new or innovative benefits may be appropriate to add coverage or access to such benefits as prescription drugs, at-home recovery services and preventive medical care. Any such innovative benefit, however, should offer uniquely different or significantly expanded coverage. (7-1-92)

019. STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS.

01. Availability of Policy Providing Basic "Core" Benefits. An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as defined in Section 017 of this rule. (7-1-92)

02. Other Benefits Prohibited. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Subsection 018.11 and in Section 020 of this rule. (7-1-92)

03. Uniformity of Benefit Plans. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this subsection and conform to the definitions in Section 004. Each benefit shall be structured in accordance with the format provided in Sections 017 and 018 and list the benefits in the order shown in this subsection. For purposes of this rule, "structure, language, and format" means style, arrangement, and overall content of a benefit. (7-1-92)

04. Other Designations. An issuer may use, in addition to the benefit plan designations required in Subsection 019.03, other designations to the extent permitted by law. (7-1-92)

05. Make-up of Benefit Plan. Make-up of benefit plans: (7-1-92)

a. Standardized Medicare supplement benefit plan "A" shall be limited to the Basic ("Core") Benefits Common to All Benefit Plans, as defined in Section 017 of this rule. (7-1-92)

b. Standardized Medicare supplement benefit plan "B" shall include only the following: The Core Benefit as defined in Section 017, plus the Medicare Part A Deductible as defined in Subsection 018.01. (7-1-92)

c. Standardized Medicare supplement benefit plan "C" shall include only the following: The Core Benefit as defined in Section 017 plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in Subsections 018.01, 018.02, and 018.08. (7-1-92)

d. Standardized Medicare supplement benefit plan "D" shall include only the following: The Core Benefit (as defined in Section 017, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit as defined in Subsections 018.01, 018.02, 018.08, and 018.10. (7-1-92)

e. Standardized Medicare supplement benefit plan "E" shall include only the following: The Core Benefit as defined in Section 017 plus Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in Subsections 018.01, 018.02, 018.08, and 018.09. (7-1-92)

f. Standardized Medicare supplement benefit plan "F" shall include only the following: The Core Benefit as defined in Section 017 plus Medicare Part A Deductible, the Skilled Nursing Facility Care, the part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Subsections 018.01, 018.02, 018.03, 018.05, and 018.08. (7-1-92)

g. Standardized Medicare supplement benefit plan "G" shall include only the following: The Core

Benefit as defined in Section 017 plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Eighty Percent (80%) of the Medicare Part B Excess Charges, Medically necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in Subsections 018.01, 018.02, 018.04, 018.08, and 018.10. (7-1-92)

h. Standardized Medicare supplement benefit plan "H" shall consist of only the following: The Core Benefit as defined in Section 017 plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in Subsections 018.01, 018.02, 018.06, and 018.09. (7-1-92)

i. Standardized Medicare supplement benefit plan "I" shall consist of only the following: The Core Benefit as defined in Section 017 of this rule, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in Subsections 018.01, 018.02, 018.05, 018.06, 018.08, and 018.10. (7-1-92)

j. Standardized Medicare supplement benefit plan "J" shall consist of only the following: The Core Benefit as defined in Section 017 plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Medical Recovery Benefit as defined in Subsections 018.01, 018.02, 018.03, 018.05, 018.07, 018.08, 018.09, and 018.10. (7-1-92)

06. Authorized Benefit Plans. Issuers are authorized to sell all ten (10) Standardized Medicare supplement benefit plans in this state. (7-1-93)

a. Drafting Note: A state may determine by statute or rule which of the above benefit plans may be sold in that state. The "core" benefit plan must be made available by all issuers. Therefore, the core benefit plan must be one of the authorized benefit plans adopted by a State. In no event, however, may a State authorize the sale of more than ten (10) standardized Medicare supplement benefit plans (that is, nine (9) plus the "core" policy) at the same time. (7-1-92)

b. Drafting Note: The Omnibus Budget Reconciliation Act of 1990 preempts state mandated benefits in Medicare supplement policies or certificates. (7-1-92)

020.)MEDICARE SELECT POLICIES AND CERTIFICATES.
No Medicare Select policies or certificates may be issued for delivery in this state unless such policy or certificate contains definitions or terms which conform to the requirements of this section. (4-1-96)T

01. Definitions. For the purpose of this section: (4-1-96)T

a. Complaint. “Complaint” means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers. (4-1-96)T

b. Grievance. “Grievance” means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers. (4-1-96)T

c. Medicare Select Issuer. “Medicare Select Issuer” means an issuer offering, or seeking to offer, a Medicare Select policy or certificate. (4-1-96)T

d. Medicare Select Policy or Medicare Select Certificate. “Medicare Select Policy” or “Medicare Select Certificate” mean respectively a Medicare supplement policy or certificate that contains restricted network provisions. (4-1-96)T

e. Network Provider. “Network Provider” means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy. (4-1-96)T

f Restricted Network Provision. "Restricted Network Provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers. (4-1-96)T

g. Service Area. "Service Area" means the geographic area approved by the director within which an issuer is authorized to offer a Medicare Select policy. (4-1-96)T

02. Authorization. The director may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to Section 020 and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the Director finds that the issuer has satisfied all of the requirements of this regulation. (4-1-96)T

03. Restrictions. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this State until its plan of operation has been approved by the director. (4-1-96)T

04. Proposed Plan of Operation. A Medicare Select issuer shall file a proposed plan of operation with the director in a format prescribed by the director. The plan of operation shall contain at least the following information: (4-1-96)T

a. Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that: (4-1-96)T

i. The services can be provided by network providers with reasonable promptness with respect to geographic location, hours or operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community. (4-1-96)T

ii. The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either to deliver adequately all services that are subject to a restricted network provision; or to make appropriate referrals. (4-1-96)T

iii. There are written agreements with network providers describing specific responsibilities.(4-1-96)T

iv. Emergency care is available twenty-four (24) hours per day and seven (7) days per week.(4-1-96)T

v. In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate. (4-1-96)T

b. A statement or map providing a clear description of the service area. (4-1-96)T

c. A description of the grievance procedure to be utilized. (4-1-96)T

d. A description of the quality assurance program, including: (4-1-96)T

i. The formal organizational structure. (4-1-96)T

ii. The written criteria for selection, retention and removal of network providers. (4-1-96)T

iii. The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted. (4-1-96)T

e. A list and description, by specialty, of the network providers. (4-1-96)T

f. Copies of the written information proposed to be used by the issuer to comply with Subsection

020.04. (4-1-96)T

g. Any information requested by the director. (4-1-96)T

05. Changes to Proposed Plan of Operation. A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the director prior to implementing the changes: (4-1-96)T

a. Changes shall be considered approved by the director after thirty (30) days unless specifically disapproved. (4-1-96)T

b. An updated list of network providers shall be filed with the director at least quarterly. (4-1-96)T

06. Non-Network Providers. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if: (4-1-96)T

a. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and (4-1-96)T

b. It is not reasonable to obtain services through a network provider. (4-1-96)T

07. Medicaid Select Policy. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers. (4-1-96)T

08. Full and Fair Disclosure. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following: (4-1-96)T

a. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with: (4-1-96)T

i. Other Medicare supplement policies or certificates offered by the issuer; and(4-1-96)T

ii. Other Medicare Select policies or certificates. (4-1-96)T

b. A description(including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers. (4-1-96)T

c. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. (4-1-96)T

d. A description of coverage for emergency and urgently needed care and other out-of-service area coverage. (4-1-96)T

e. A description of limitations on referrals to restricted network providers and to other providers. (4-1-96)T

f. A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer. (4-1-96)T

g. A description of the Medicare Select issuer's quality assurance program and grievance procedure. (4-1-96)T

09. Requirements Prior to Sale. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection 020.08 of this rule and that the applicant understands the restrictions of the Medicare Select policy or certificate. (4-1-96)T

10. Complaints and Written Grievances. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures:(4-1-96)T

a. The grievance procedure shall be described in the policy and certificates and in the outline of coverage. (4-1-96)T

b. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer. (4-1-96)T

c. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action. (4-1-96)T

d. If a grievance is found to be valid, corrective action shall be taken promptly. (4-1-96)T

e. All concerned parties shall be notified about the results of a grievance. (4-1-96)T

f. The issuer shall report no later than each March 31st to the director regarding its grievance procedure. The report shall be in a format prescribed by the director and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances. (4-1-96)T

11. Medicare Select Issuer Must Offer all Products. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer. For these purposes, the following should apply: (4-1-96)T

a. At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months. (4-1-96)T

b. For the purposes of Subsection 020.11.b., a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges. (4-1-96)T

12. Continuation of Coverage. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment. Such plans shall: (4-1-96)T

a. Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability. (4-1-96)T

b. For the purposes of Subsection 020.11.b., a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges. (4-1-96)T

13. Reasonable Request For Data. A Medicare Select issuer shall comply with reasonable request 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. (4-1-96)T

021. OPEN ENROLLMENT.

01. Open Enrollment Period Following Eligibility for Medicare. An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this State, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) months period beginning with the first day of the first month in which an individual is both sixty-five (65) years of age or olderand is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age. (4-1-96)T

02. Preexisting Condition Exclusion. Subsection 032 shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before it the coverage became effective. (4-1-96)T

022. STANDARDS FOR CLAIMS PAYMENT.

01. Compliance with Section 1882(c)(3). An issuer shall comply with section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(c) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by: (7-1-92)

a. Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice; (7-1-92)

b. Notifying the participating physician or supplier and the beneficiary of the payment determination. (7-1-92)

c. Paying the participating physician or supplier directly; (7-1-92)

d. Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent; (7-1-92)

e. Paying user fees for claim notices that are transmitted electronically or otherwise; and (7-1-92)

f. Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers. (7-1-92)

02. Certificate of Compliance. Compliance with the requirements set forth in Subsection 022.01 above shall be certified on the Medicare supplement insurance experience reporting form. (7-1-92)

023. LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM.

01. Loss Ratio Standards. (7-1-92)

a. A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form: (7-1-92)

i. At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies, or (4-1-96)T

ii. At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of

individual policies. (4-1-96)T

b. Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than a reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices. (4-1-96)T

c. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards. (7-1-92)

d. For purposes of applying Subsection 023.01.a. policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies. (4-1-96)T

02. Refund or Credit Calculations. (7-1-92)

a. An issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan. (4-1-96)T

b. If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded. (7-1-92)

c. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by the September 30 following the experience year upon which the refund or credit is based. (4-1-96)T

d. For the purposes of this section, policies or certificates issued prior to July 1, 1992, the effective date of the states regulation implementing the requirements of OBRA [990], the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after July 1, 1992. The first such report shall be due by May 31, 1994. (4-1-96)T

03. Annual Filing of Premium Rates. (7-1-92)

a. An issuer of Medicare supplement policies and certificates issued before or after the effective date of IDAPA 18.01.54 in this State shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this State shall file with the director in accordance with the applicable filing procedures of this State: (7-1-92)

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

shall accompany the filing. (4-1-96)T

ii. An issuer shall make such premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date. (4-1-96)T

iii. If an issuer fails to make premium adjustments acceptable to the director, the director may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section. (7-1-92)

b. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate. (4-1-96)T

04. Public Hearings. The director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of IDAPA 18.01.54 if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director. (4-1-96)T

024. FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES.

01. Policies and Certificates. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the director in accordance with filing requirements and procedures prescribed by the director. (7-1-92)

02. Premium Rates. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director. (7-1-92)

03. Attained Age Rating Prohibited. With respect to Medicare supplement policies that conform to the Ten Standard Benefit Plans developed by the National Association of Insurance Commissioners and adopted by the state of Idaho July 1, 1992 under IDAPA 18.01.54 sold to residents of this state and all those sold on or after January 1, 1995, it is an unfair practice and an unfair method of competition for any issuer, insurer, or licensee to use the increasing age of an insured, subscriber or participant as the basis for increasing premiums or prepayment charges for policyholders who initially purchase a policy after January 1, 1995. This rule is retroactive to December 2, 1994, and supersedes the contrary temporary rule that went into effect on that date in all regards. This rule explicitly authorizes both issue age ratings and community ratings consistent with the prohibition of attained age ratings and allows companies to resubmit for approval issue age ratings previously rejected. (12-2-94)

04. Limitation on Filing of Forms for Each Standard Plan. (7-1-92)

a. Except as provided in Subsection 024.03.b., an issuer shall not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan. (7-1-92)

b. An issuer may offer, with the approval of the director, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases: (7-1-92)

i. The inclusion of new or innovative benefits; (7-1-92)

ii. The addition of either direct response or agent marketing methods; (7-1-92)

iii. The addition of either guaranteed issue or underwritten coverage; (7-1-92)

iv. The offering of coverage to individuals eligible for Medicare by reason of disability. (7-1-92)

v. For the purposes of this section, a "type" means an individual policy or a group policy. (7-1-92)

05. Continued Availability of Policy Form. (7-1-92)

a. Except as provided in Subsection 024.04.a.i., an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this rule that has been approved by the director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months. (7-1-92)

b. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the director in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the director, the issuer shall no longer offer for sale the policy form or certificate form in this state. (7-1-92)

ii. An issuer that discontinues the availability of a policy form or certificate form pursuant to Subsection 024.04.a.i. shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate. (7-1-92)

iii. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection. (7-1-92)

c. A change in the rating structure or methodology shall be considered a discontinuance under Subsection 024.04.a. unless the issuer complies with the following requirements: (7-1-92)

i. The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates. (7-1-92)

ii. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The director may approve a change to the differential which is in the public interest. (7-1-92)

06. Refund or Credit Calculation. (7-1-92)

a. Except as provided in Subsection 024.05.b., the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 023. (7-1-92)

b. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation. (7-1-92)

025. PERMITTED COMPENSATION ARRANGEMENTS.

01. Limitations on First Year Commission. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period. (7-1-92)

02. Limitation on Renewal Commissions. The commission or other compensation provided in

subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years. (7-1-92)

03. Limitation on Commissions Involving Replacement. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced. (7-1-92)

04. Compensation. For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees. (7-1-92)

026. REQUIRED DISCLOSURE PROVISIONS.

01. General Rules. (7-1-92)

a. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract to be issued. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, or renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age. (4-1-96)T

b. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy. (4-1-96)T

c. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import. (7-1-92)

d. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations." (7-1-92)

e. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason. (7-1-92)

f. Issuers of disability policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person(s) eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than twelve (12) point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this rule. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered. (4-1-96)T

g. For the purposes of this section, "form" means the language, format, type size, type proportional

spacing, bold character, and line spacing. (4-1-96)T

02. Notice Requirements. (7-1-92)

a. As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the director. The notice shall: (4-1-96)T

i. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and (7-1-92)

ii. Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare. (7-1-92)

b. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension. (7-1-92)

c. Such notices shall not contain or be accompanied by any solicitation. (7-1-92)

03. Outline of Coverage Requirements for Medicare Supplement Policies. (7-1-92)

a. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant; and (4-1-96)T

b. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name: "NOTICE: Read this outline of overage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued." (7-1-92)

c. The outline of coverage provided to applicants pursuant to this Section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All plans A-J shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated. (7-1-92)

d. The following items shall be included in the outline of coverage in the order prescribed below. (7-1-92)

COMPANY NAME

Outline of Medicare Supplement Coverage Cover Page:

Benefit Plan(s)_____ insert letter(s) of plan(s) being offered

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

BASIC BENEFITS: Included in All Plans. Hospitalization: Part A coinsurance plus coverage for three hundred sixty-five (365) additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (twenty percent (20%) of Medicare-approved expenses).

Blood: First three (3) pints of blood each year.

PREMIUM INFORMATION

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

Use this outline to compare benefits and premiums among policies:

READ YOUR POLICY VERY CAREFULLY

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

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

POLICY REPLACEMENT

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

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 responses:)

(insert company's name) is not connected with Medicare.

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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 rule. An issuer may use additional benefit plan designations on these charts pursuant to Section 9D of this rule.

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

DRAFTING NOTE: The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate. (7-1-93)

04. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies. Any disability insurance policy or certificate, other than a Medicare supplement policy; or a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. Subsection 1395, et seq.), disability income policy; or other policy identified in this rule, issued for delivery in this State to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language:

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

Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Appendix D, Paragraph 1 shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate. (4-1-96)T

027. REQUIREMENT FOR APPLICATION FORMS AND REPLACEMENT COVERAGE.

01. Questions Regarding Other-In-Force Insurance. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other disability policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used. Statements: (7-1-93)

a. You do not need more than one Medicare supplement policy. (7-1-93)

b. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. (4-1-96)T

c. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. (4-1-96)T

d. The benefits and premiums under your Medicare supplement policy can be suspended if requested during your entitlement to benefits under Medicaid for twenty-four (24) months. You must request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within 90 days of losing Medicaid eligibility. (4-1-96)T

e. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

QUESTIONS

To the best of your knowledge: (4-1-96)T

i. Do you have another Medicare supplement insurance policy or certificate in force?

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

If so, with which company?

ii. Do you have any other health insurance coverages that provide benefits similar this Medicare supplement policy would duplicate?

If so, with which company?

What kind of policy? (4-1-96)T

iii. If the answer to question i. or ii. is yes, do you intend to replace these medical or health policies with this policy certificate? (7-1-93)

iv. Are you covered for medical assistance throught the state Medicaid program:? (4-1-96)T

(1) As a Specified Low-Income Medicare Beneficiary (SLMB)? (4-1-96)T

(2) As a Qualified Medicare Beneficiary (QMB)? (4-1-96)T

(3) For other Medicaid medical benefits? (4-1-96)T

02. Agent Requirements. Agents shall list any other health insurance policies they have sold to the applicant. (7-1-93)

i. List policies sold which are still in force. (7-1-93)

ii. List policies sold in the past five (5) years which are no longer in force. (7-1-93)

03. Direct Response Issuer. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy. (7-1-93)

04. Notification of Existing Insurer Upon Replacement. Where replacement is involved, the replacing insurer shall notify by written communication the existing insurer of the proposed replacement. Such existing insurance shall be identified by the name of the insurer, name of insured and contract number. The written communication shall be made within five (5) working days of the date the application is received in the replacing insurer's home or regional office or the date the proposed policy or contract is issued, whenever is sooner. (7-1-93)

05. Notification of Applicant Upon Replacement. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of such notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage. (7-1-93)

06. Form of Notice. The notice required by subsection 026.05 above for an issuer shall be provided in substantially the following form in no less than twelve (12) point type: (7-1-93)

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE

(Insurance company's name and address)

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

According to your application (information you have furnished), you intend to terminate existing Medicare supplement and replace it with a policy to be issued by (Company Name) Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

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

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

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

__ Additional benefits

__ No change in benefits, but lower premiums

__ Fewer benefits and lower premiums

__ Other (please specify)

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

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

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. If the policy or certificate is guaranteed issue, this paragraph need not appear.

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

(Signature of Agent, Broker or Other Representative*)

[Typed Name and Address of Issuer Agent or Broker]

(Applicant's Signature)

_____
(Date)

*Signature not required for direct response sales.

Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation. (4-1-96)T

028. FILING REQUIREMENTS FOR ADVERTISING.
An issuer shall provide a copy of any Medicare Supplement advertisement intended for use in this State whether through written, radio or television medium to the Director of Insurance of this State for review or approval by the Director to the extent it may be required under state law. (7-1-93)

029. STANDARDS FOR MARKETING.

01. Marketing Procedures. An issuer directly or through its producers, shall: (7-1-93)

a. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate. (7-1-93)

b. Establish marketing procedures to assure excessive insurance is not sold or issued. (7-1-93)

c. Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:
"Notice to buyer: This policy may not cover all your medical expenses." (7-1-93)

d. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has disability insurance and the types and amounts of any such insurance. (7-1-93)

e. Establish auditable procedures for verifying compliance with this Subsection 028.01. (7-1-93)

02. Prohibited Acts and Practices. In addition to the practices prohibited in Chapter 13, Title 41, Idaho Code, the following acts and practices are prohibited: (7-1-93)

a. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer. (7-1-93)

b. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat whether explicit or implied, or undue pressure to purchase or recommends the purchase of insurance. (7-1-93)

c. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company. (7-1-93)

03. Use of Terms "Medicare Supplement," "Medigap" or "Medicare Wrap-Around." The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this rule. (7-1-93)

030. APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE.

01. Obligation of Agent in Making Recommendation. In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement. (7-1-93)

02. Multiple Policies. Any sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited. (7-1-93)

031. REPORTING OF MULTIPLE POLICIES.

01. Report Concerning Individual Issued More than One Medicare Supplement Policy. On or before March 1 of each year, an issuer shall report the following information for every individual resident of this State for which the issuer has in force more than one Medicare supplement policy or certificate: (7-1-93)

a. Policy and certificate number; and (7-1-93)

b. Date of Issuance. (7-1-93)

02. Replacement of Policy or Certificate in Effect for Six (6) Months. The items set forth above must be grouped by individual policyholder. (7-1-93)

Editors Note: Appendix B contains a reporting form for compliance with this section. (7-1-93)

032. PROHBITION AGAINST PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATE.

01. Waive Applicable Time Periods. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy. (7-1-93)

02. In Effect for at Least Six (6) Months. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods. (7-1-93)

033. SEVERABILITY.
If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby. (7-1-93)

034. -- 999. (RESERVED)

APPENDIX A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR _____

Type _____ SMSBP (w) _____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Person Completing This Exhibit _____

Title _____ Telephone Number _____

(a) (b)

Earned Incurred
PremiumClaims (y)

1. Current Year's Experience

a. Total (all policy years)

b. Current year's issues (z)

c. Net (for reporting purposes = 1a - 1b ___ - ___

2. Past Years' Experience
(All Policy Years) _____ _____

3. Total Experience (Net Current Year + Past Years' Experience)
_____ _____

4. Refunds last year (Excluding Interest)

5. Previous Since Inception (Excluding Interest)

6. Refunds Since Inception (Excluding Interest)

7. Benchmark Ratio Since Inception
(SEE WORKSHEET FOR RATIO 1)

8. Experienced Ratio Since Inception

Total Actual Incurred Claims (line 3, col b) = Ratio 2

Tot. Earned Prem. (line 3, col a) - Refunds Since Inception (line 6)

9. Life Years Exposed Since Inception _____

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

10. Tolerance Permitted (obtained from credibility table) _____

11. Adjustment to Incurred Claims for Credibility

Ration 3 = Ratio 2 + Tolerance

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

If Ration 3 is less than the benchmark ratio, then proceed.

12. Adjusted Incurred Claims =

Tot. Earned Premiums (line 3, col a) - Refunds Since Inception (line 6) x Ratio 3 (line 11)

13. Refund = Total Earned Premiums (line 3, col a) - Refunds Since Inception (line 6) -

Adjusted Incurred Claims (line 12)

Benchmark Ration (Ratio 1)

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

Medicare Supplement Credibility Table

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

APPENDIX B

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR _____

Type _____ SMSBP (w) _____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

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

(x) Includes model leadings and fees charged.

(y) Excludes Active Life Reserves.

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

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

_____
Signature

_____
Name - Please Type

_____
Title

_____
Date

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

TYPE_____SMSBP (p)_____ FOR THE STATE OF_____ Company

Name_____ NAIC Group Code_____NAIC

Company Code _____ Address_____

Person Completing This Exhibit_____ Title_____

Telephone Number_____

(a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (o)
Earned Cumulative Cumulative Policy Year

Year Premium Factor (b) x (c) Loss Ratio (d) x (e) Factor (b) x (g) Loss Ratio (h) x (i) Loss Ratio
Total: (k): (l): (m): (n):

1	2.770	0.507	0.000	0.000	0.46
2	4.175	0.567	0.000	0.000	0.63

3	4.175	0.567	1.194	0.759	0.75
4	4.175	0.567	2.245	0.771	0.77
5	4.175	0.567	3.170	0.782	0.8
6	4.175	0.567	3.998	0.792	0.82
7	4.175	0.567	4.754	0.802	0.84
8	4.175	0.567	5.445	0.811	0.87
9	4.175	0.567	6.075	0.818	0.88
10	4.175	0.567	6.650	0.824	0.88
11	4.175	0.567	7.176	0.828	0.88
12	4.175	0.567	7.655	0.831	0.88
13	4.175	0.567	8.093	0.834	0.89
14	4.175	0.567	8.493	0.837	0.89
15	4.175	0.567	8.684	0.838	0.89

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

(a): Year 1 is the current calendar year - 1 (b): For the calendar year on the appropriate line in column (a), Year 2 is the current calendar year - 2 the premium earned during that year for policies issued in (etc.) that year. (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989; etc.)

(o): These loss ratios are not explicitly used in computing the benchmark (p): "SMSBP" = Standardized Medicare loss ratios.

They are the loss ratios, on a policy year basis, Supplement Benefit Plan which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only. Appendix B

FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

Phone Number: _____

Due: March 1, annually

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

Policy and Certificate # _____ Date of Issuance _____

_____
Signature

_____
Name and Title (please type)

_____
Date

Appendix C

FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES

Company Name:
Address:
Phone Number:
Due: March 1, Annually

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

Policy and Certificate # Date of Issuance

Signature

Name and Title (Please type)

Date

Appendix D

DISCLOSURE STATEMENTS

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

1. Federal law, P.L. 103-432, prohibits the sale of a health insurance policy (the term policy or policies includes certificates) that duplicate Medicare benefits unless it will pay benefits without regard to other health coverage and it includes the prescribed disclosure statement on or together with the application.

2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement.

4. Property/casualty and life insurance policies are not considered health insurance.

5. Disability income policies are not considered to provide benefits that duplicate Medicare.

6. The federal law does not pre-exempt state laws that are more stringent than the federal requirements.

7. The federal law does not pre-exempt existing state form filing requirements.