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Regulation of the

Insurance Department

Concerning

Medicare Supplement Insurance

Regulations adopted after July 1, 2013, become effective upon posting to the Connecticut eRegulations System, or at a later date if specified within the regulation.

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Form ICM-ECOPY (NEW 6/2015)
State of Connecticut
Secretary of the State

IMPORTANT NOTICE FOR CONNECTICUT STATE AGENCIES
This form should be used only for regulations first noticed *on and after March 23, 2015.*

Electronic Copy Certification Statement

(Submitted in accordance with the provisions of section 4-172 of the Connecticut General Statutes)

Regulation of the
Insurance Department
Concerning
Medicare Supplement Insurance

Approved by the Legislative Regulation Review Committee: **March 26, 2019**
eRegulations System Tracking Number: **PR-2018-021**

I hereby certify that the electronic copy of the above-referenced regulation submitted herewith to the Secretary of the State is a true and accurate copy of the regulation approved in accordance with sections 4-169 and 4-170 of the *Connecticut General Statutes*.

And I further certify that in accordance with the approval of Legislative Regulation Review Committee, all required technical corrections, page substitutions and deletions, if any, have been incorporated into said regulation.

In testimony whereof, I have hereunto set my hand on **March 29, 2019**.

Andrew N. Mais
Commissioner
Insurance Department

State of Connecticut
Regulation of
Insurance Department
Concerning
Medicare Supplement Insurance

Section 1. Section 38a-495a-2 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 38a-495a-2. Definitions

[As used in Sections 38a-495a-1 to 38a-495a-20, inclusive:**]**

As used in sections 38a-495a-1 to 38a-495a-20, inclusive, of the Regulations of Connecticut State Agencies:

[(a)] (1) "Applicant" means:

[(1)] (A) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; **[**or**]** and

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

[(b)] (2) "Bankruptcy" means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

[(c)] (3) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

[(d)] (4) "Certificate Form" means the form on which the certificate is delivered or issued for delivery by the issuer.

[(e)] (5) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

[(f)]

[(1)] (6) (A) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

[(A)] (i) a group health plan;

[(B)] (ii) health insurance coverage;

[(C)] (iii) part a or part b of title xviii of the Social Security Act (Medicare);

[(D)] (iv) title xix of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;

[(E)] (v) chapter 55 of title 10 United States Code (medical and dental coverage) (CHAMPUS);

[(F)] (vi) a medical care program of the Indian Health Service or of a tribal organization;

[(G)] (vii) a state health benefits risk pool;

[(H)] (viii) a health plan offered under chapter 89 of title 5 United States Code (federal employees health benefits program);

[(I)] (ix) a public health plan as defined in federal regulation; and

[(J)] (x) a health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

[(2)] (B) "Creditable coverage" shall not include one or more, or any combination of, the

following:

[(A)] (i) coverage only for accident or disability income insurance, or any combination thereof;

[(B)] (ii) coverage issued as a supplement to liability insurance;

[(C)] (iii) liability insurance, including general liability insurance and automobile liability insurance;

[(D)] (iv) workers' compensation or similar insurance;

[(E)] (v) automobile medical payment insurance;

[(F)] (vi) credit-only insurance;

[(G)] (vii) coverage for on-site medical clinics; and

[(H)] (viii) other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

[(3)] (C) "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

[(A)] (i) limited scope dental or vision benefits;

[(B)] (ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

[(C)] (iii) such other similar, limited benefits as are specified in federal regulations.

[(4)] (D) "Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

[(A)] (i) coverage only for a specified disease or illness; and

[(B)] (ii) hospital indemnity or other fixed indemnity insurance.

[(5)] (E) "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

[(A)] (i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

[(B)] (ii) coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and

[(C)] (iii) similar supplemental coverage provided to coverage under a group health plan.

[(g)] (7) "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. section 1002 (Employee Retirement Income Security Act).

[(h)] (8) "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

[(i)] (9) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, health care centers, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

[(j)] (10) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

[(k)] (11) "Medicare Advantage plan" means a plan of coverage for health benefits under Medicare part C, and includes:

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

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

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

[(*l*)] (12) "Medicare supplement policy" means a group or individual policy of insurance or a subscriber contract, 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. [s] section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. "Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under § 1833(a)(1)(A) of the Social Security Act.

[(m)] (13) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

[(n)] (14) "Pre-standardized plan" means a group or individual policy of Medicare supplement insurance issued prior to July 30, 1992.

[(o)] (15) "1992 Standardized Medicare supplement benefit plan", "1992 Standardized benefit plan" or "1992 plan" means a group or individual policy of Medicare supplement insurance issued on or after July 30, 1992, and with an effective date for coverage prior to June 1, 2010.

[(p)] (16) "2010 Standardized Medicare supplement benefit plan", "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare supplement insurance issued with an effective date for coverage on or after June 1, 2010.

[(q)] (17) "Secretary" means the secretary of the United States Department of Health and Human Services.

Sec. 2. Section 38a-495a-4 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 38a-495a-4. Policy provisions

(a) Except for permitted preexisting condition clauses as described in **[**section**]** sections 38a-495a-4a(a)(1), 38a-495a-5(a) (1), and 38a-495a-5a(a)(1) of the Regulations of Connecticut State Agencies, 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.

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

(c) No Medicare supplement policy or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare.

(d) (1) Subject to sections 38a-495a-5(a)(4), 38a-495a-5(a)(5) and 38a-495a-5(a)(7) of the Regulations of Connecticut State Agencies, a Medicare supplement policy with benefits for outpatient prescription drugs in existence as of December 31, 2005 shall be renewed for current policyholders who do not enroll in Medicare Part D at the option of the policyholder.

(2) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

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

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

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

Sec. 3. Section 38a-495a-5a of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 38a-495a-5a. Benefit standards for 2010 standardized Medicare supplement benefit plan policies or certificates issued for delivery with an effective date for coverage on or after June 1, 2010

The [following] standards established in this section are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate on or after June 1, 2010 unless it complies with [these] benefit standards established in this section. No issuer may offer any 1992 Medicare standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage on or after July 30, 1992, and before June 1, 2010, remain subject to the requirements of 38a-495a-5 and 38a-495a-6 of the Regulations of Connecticut State Agencies.

(a) **General Standards**. The standards established in this subsection apply to Medicare supplement policies and certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010 and are in addition to all other requirements of sections 38a-495a-1 to 38a-495a-21, inclusive, of the Regulations of Connecticut State Agencies.

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

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

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

(4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable.

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

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

(C) If a Medicare supplement policy is terminated by a group policyholder and is not replaced as provided under subparagraph (E) of this subdivision of this section, the issuer shall offer certificateholders an individual Medicare supplement policy which, at the option of the certificateholder, (i) provides for continuation of the benefits contained in the group policy, or (ii) provides for benefits that otherwise meet the requirements of this subsection.

(D) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall offer the certificateholder (i) the conversion opportunity described in subparagraph (C) of this subdivision, or (ii) at the option of the group policyholder, continuation of coverage under the group policy.

(E) If a group Medicare supplement policy is replaced by another group Medicare supplement

policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

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

(7) (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 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, provided the policyholder or certificateholder notifies the issuer of the policy or certificate not later than ninety days after the date the individual becomes entitled to assistance.

(B) If such suspension occurs and the policyholder or certificateholder loses entitlement to medical assistance under Title XIX of the Social Security Act, the policy or certificate shall be automatically reinstituted effective as of the date of termination of entitlement provided the policyholder or certificateholder provides notice of loss of entitlement not later than ninety days after the date of loss and pays the premium attributable to the period.

(C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended, for any period that may be provided by federal regulation, at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan, as defined in section [1862 (b) (1) (A) (v)] 1862(b)(1)(A)(v) of the Social Security Act. If such suspension occurs and the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted effective as of the date of loss of coverage, provided the policyholder provides notice of loss of coverage not later than ninety days after the date of the loss and pays the premium attributable to the period as of the date of termination of enrollment in the group health plan.

(D) Reinstitution of coverages as set forth in subparagraphs (B) and (C) of this subdivision shall:**[**(i) not provide for any waiting period with respect to treatment of preexisting conditions, and (ii) shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension.**]**

(i) Not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Provide for resumption of coverage that is substantially equivalent to the coverage that was in effect before the date of suspension; and

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

(b) **Standards for Basic Core Benefits Common to Medicare Supplement Plans A, B, C, D, F, F with High Deductible, G, M, and N**. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate that includes only the following basic core package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu of it:

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by

Medicare from the 61st day through the 90th day in any Medicare benefit period;

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

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

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

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

(6) Hospice Care: coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

(c) **Standards for Additional Benefits.** The following additional benefits shall be included in Medicare supplement benefit plans B, C, D, F, F with High Deductible, G, M, and N as set forth in section 38a-495a-6a of the Regulations of Connecticut State Agencies:

(1) Medicare Part A Deductible: Coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

(2) Medicare Part A Deductible: Coverage for fifty percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

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

(4) Medicare Part B Deductible: Coverage for one hundred percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

(5) One Hundred Percent of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge;

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

Sec. 4. Section 38a-495a-6a of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 38a-495a-6a. Standard Medicare supplement benefit plans for 2010 standardized Medicare supplement benefit plan policies or certificates with an effective date for coverage on or after [June 10, 2010] June 1, 2010.

(a) The following standards are applicable to all Medicare supplement policies or certificates

delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate on or after June 1, 2010 unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates with an effective date for coverage on or after July 30, 1992, and before June 1, 2010, remain subject to the requirements of sections 38a-495a-5 and 38a-495a-6 of the Regulations of Connecticut State Agencies.

(1) (A) 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 38a-495a-5a of the Regulations of [the] Connecticut State Agencies.

(B) If an issuer makes available any of the additional benefits set forth in section 38a-495a-5a(c) of the Regulations of Connecticut State Agencies or offers standardized benefit plan K or L as set forth in this section, the issuer shall also make available to each prospective policyholder and certificateholder standardized benefit plan C or F, as set forth in this section, in addition to the basic core benefit plan required under subparagraph (A) of this subdivision.

(b) No groups, packages or combinations of Medicare supplement benefits other than those listed in this section and section 38a-495a-7 of the Regulations of Connecticut State Agencies shall be offered for sale in this state.

(c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this section and conform to the definitions in section 38a-495a-2 of the Regulations of Connecticut State Agencies. Each benefit shall be structured in accordance with section 38a-495a-5a of the Regulations of Connecticut State Agencies, or, in the case of plans K or L, this section, and list the benefits in the order shown. For purposes of this section, “structure”, “language”, “designation” and “format” means style, arrangement and overall content of a benefit.

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

(e) **Make-up of 2010 standardized benefit plans:**

(1) Standardized Medicare supplement benefit plan A shall include only the following: The basic core benefit as set forth in section 38a-495a-5a(b) of the Regulations of Connecticut State Agencies.

(2) Standardized Medicare supplement benefit plan B shall include only the following: The basic core benefit as set forth in section 38a-495a-5a(b) of the Regulations of Connecticut State Agencies, plus one hundred percent of the Medicare Part A deductible, as set forth in section [38a-495a-5a(c)(1)] 38a-495a-5a(c)(1) of the Regulations of Connecticut State Agencies.

(3) Standardized Medicare supplement benefit plan C shall include only the following: The basic core benefit as set forth in section 38a-495a-5a(b) of the Regulations of Connecticut State Agencies, plus one hundred percent of the Medicare Part A deductible, skilled nursing facility care, one hundred percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country, as set forth in section 38a-495a-5a(c) of the Regulations of Connecticut State Agencies.

(4) Standardized Medicare supplement benefit plan D shall include only the following: The basic core benefit as set forth in section 38a-495a-5a(b) of the Regulations of Connecticut State Agencies, plus one hundred percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country, as set forth in section 38a-495a-5a(c) of the Regulations of Connecticut State Agencies.

(5) Standardized Medicare supplement plan F shall include only the following: The basic core benefits as set forth in section 38a-495a-5a(b) of the Regulations of Connecticut State Agencies, plus one hundred percent of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent of the Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country, as set forth in section 38a-

495a-5a(c) of the Regulations of Connecticut State Agencies.

(6) Standardized Medicare supplement plan F with High Deductible shall include only the following:

(A) The basic core benefit as set forth in section 38a-495a-5a(b) of the Regulations of Connecticut State Agencies, plus one hundred percent of the Medicare Part A deductible, skilled nursing facility care, one hundred percent of the Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country, as set forth in section 38a-495a-5a(c) of the Regulations of Connecticut State Agencies, plus one hundred percent of covered expenses following payment of the annual deductible set forth in subparagraph (B) of this subdivision.

(B) The annual deductible in plan F with High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1500 and shall be adjusted annually from 1999 by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

(7) Standardized Medicare supplement plan G shall include only the following: The basic core benefit as set forth in section 38a-495a-5a(b) of the Regulations of Connecticut State Agencies, plus one hundred percent of the Medicare Part A deductible, skilled nursing facility care, one hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country, as set forth in section 38a-495a-5a(c) of the Regulations of Connecticut State Agencies. Effective January 1, 2020, the standardized benefit plans described in section 38a-495a-6b of the Regulations of Connecticut State Agencies may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

(8) Standardized Medicare supplement plan K shall include only the following:

(A) Part A hospital coinsurance 61st through 90th days: Coverage of one hundred percent of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(B) Part A hospital coinsurance, 91st through 150th days: Coverage of one hundred percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

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

(D) Medicare Part A deductible: Coverage for fifty percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as set forth in subparagraph (J) of this subdivision;

(E) Skilled Nursing Facility Care: Coverage for fifty percent of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as set forth in subparagraph (J) of this subdivision;

(F) Hospice Coverage: Coverage for fifty percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as set forth in subparagraph (J) of this subdivision;

(G) Blood: Coverage for fifty percent under Medicare Part A or B, of the reasonable cost of the

first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as set forth in subparagraph (J) of this subdivision;

(H) Part B Cost Sharing: Except for coverage provided in subparagraph (I) of this subdivision, coverage for fifty percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as set forth in subparagraph (J) of this subdivision:

(I) Part B Preventive Services: Coverage of one hundred percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(J) Cost Sharing After Out-Of-Pocket Limits: Coverage of one hundred percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of [$4620 in 2009] $5,240 in 2018, indexed each year by the appropriate inflation adjustment specified by the secretary.

(9) Standardized Medicare supplement plan L shall include only the following:

(A) The benefits set forth in subparagraphs (A), (B), (C) and (I) of subdivision (8) of this subsection;

(B) The benefits set forth in subparagraphs (D), (E), (F) and (G) of subdivision (8) of this subsection, but substituting seventy-five percent for fifty percent, and

(C) The benefit set forth in subparagraph (J) of subdivision (8) of this subsection, but substituting [$2310 for $4620] $2,620 for $5,240.

(10) Standardized Medicare supplement plan M shall include only the following: The basic core benefits as set forth in section 38a-495a-5a(b) of the Regulations of Connecticut State Agencies, plus fifty percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country, as set forth in section 38a-495a-5a(c) of the Regulations of Connecticut State Agencies.

(11) Standardized Medicare supplement plan N shall include only the following: The basic core benefits as set forth in section 38a-495a-5a(b) of the Regulations of Connecticut State Agencies, plus one hundred percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country, as set forth in section 38a-495a-5a(c) of the Regulations of Connecticut State Agencies with copayments in the following amounts:

(A) the lesser of twenty dollars or the Medicare Part B coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists; and

(B) the lesser of fifty dollars or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

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

Sec. 5. The Regulations of Connecticut State Agencies are amended by adding section 38a-495a-6b as follows:

(NEW) Sec. 38a-495a-6b. Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefits Plan Policies or Certificates Issued for Delivery to Individuals Newly Eligible for Medicare on or After January 1, 2020

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires that the standards set forth in this section be applied to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. Benefits plan standards applicable to Medicare supplement policies and certificates issued to individuals newly eligible for Medicare on or after January 1, 2020 must comply with the benefit standards of subsections (a)(1) and (a)(5) of this section. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of sections 38a-495a-5 and 38a-495a-5a of the Regulations of Connecticut State Agencies.

(a) **Benefit Requirements.** The standards and requirements of section 38a-495a-6a of the Regulations of Connecticut State Agencies shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

(1) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in subsection (e)(3) of section 38a-495a-6a of the Regulations of Connecticut State Agencies, but shall not provide coverage for one hundred percent or any portion of the Medicare Part B deductible.

(2) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in subsection (e)(5) of section 38a-495a-6a of the Regulations of Connecticut State Agencies, but shall not provide coverage for one hundred percent of any portion of the Medicare Part B deductible.

(3) Standardized Medicare supplement benefit plans C, F, and F With High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

(4) Standardized Medicare supplement benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and shall provide the benefits contained in subsection (e)(6) of section 38a-495a-6a of the Regulations of Connecticut State Agencies, but shall not provide coverage for one hundred percent or any portion of the Medicare Part B deductible; provided further that the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.

(5) The reference to Plans C or F contained in subsection (a)(1)(B) of section 38a-495a-6a of the Regulations of Connecticut State Agencies is deemed a reference to Plans D or G for purposes of this section.

(b) **Applicability to certain Individuals**. This section applies only to individuals who are deemed to be eligible for benefits under Section 226(a) of the Social Security Act on or after January 1, 2020, or individuals who are newly eligible for Medicare on or after January 1, 2020:

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

(2) By reason of entitlement to benefits under part A pursuant to Section 226(b) or 226A of the Social Security Act.

(c) **Guaranteed Issue for Eligible Persons.** For purposes of subsection (e) of section 38a-495a-8a of the Regulations of Connecticut State Agencies in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F With High Deductible) shall be deemed to be a reference to Medicare supplement policy

D or G (including G With a High Deductible), respectively, that meet requirements of subsection (a) of this section.

(d) **Applicability to Waivered States**. In the case of a state described in Section 1882 (p)(6) of the Social Security Act ("waivered" alternative simplification states), MACRA prohibits the coverage of the Medicare Part B deductible for any Medicare supplement policy sold or issued to an individual who is newly eligible for Medicare on or after January 1, 2020.

(e) **Offer of Redesignated Plans to Individuals Other Than Newly Eligible Individuals**. On or after January 1, 2020, the standardized benefit plans described in subsection (a)(4) of this section may be offered to any individual who was eligible for Medicare prior to January 1, 2020, in addition to the standardized plans described in subsection (e) of section 38a-495a-6a of the Regulations of Connecticut State Agencies.

Sec. 6. Section 38a-495a-8a of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 38a-495a-8a. Guaranteed issue for eligible persons

(a) **Guaranteed Issue**

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

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

(b) **Eligible Persons** An eligible person is an individual described in any of the following subdivisions:

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

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a program of all-inclusive care for the elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

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

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

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

[(C)] (D) The individual demonstrates, in accordance with guidelines established by the secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

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

[(D)] (E) The individual meets such other exceptional conditions as the secretary may provide.

(3) (A) The individual is enrolled with:

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

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

(iii) An organization under an agreement under section [1833(a) (1) (A)] 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(iv) An organization under a Medicare Select policy; and

(B) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subdivision (2) of this subsection.

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

(A) (i) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(ii) Of other involuntary termination of coverage or enrollment under the policy;

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

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

(5) (A) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a Medicare Select policy; and

(B) The subsequent enrollment described in subparagraph (A) of this subdivision is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

(6) The individual, upon first becoming eligible for benefits under part A of Medicare at age 65, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment.

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

(c) **Guaranteed issue time periods**

(1) In the case of an individual described in subdivision (1) of subsection (b) of this section, the guaranteed issue period: (A) [begins] Begins on the later of (i) the date the individual receives a

notice of termination or cessation of all supplemental health benefits (or, if such notice is not received, notice that a claim has been denied because of such a termination or cessation) or (ii) the date the applicable coverage terminates or ceases; and (B) ends 63 days after the date of the applicable notice;

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

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

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

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

(6) In the case of an individual described in subsection (b) but not described in the preceding subdivisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(d) **Extended Medigap access for interrupted trial periods**

(1) In the case of an individual described in subdivision (5) of subsection (b) of this section (or deemed to be so described, pursuant to this subdivision) whose enrollment with an organization or provider described in subparagraph (A) of subdivision (5) of subsection (b) of this section is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in subdivision (5) of subsection (b) of this section;

(2) In the case of an individual described in subdivision (6) of subsection (b) of this section (or deemed to be so described, pursuant to this subdivision) whose enrollment with a plan or in a program described in subdivision (6) of subsection (b) of this section is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in subdivision (6) of subsection (b) of this section; and

(3) For purposes of subdivisions (5) and (6) of subsection (b) of this section no enrollment of an individual with an organization or provider described in subparagraph (A) of subdivision (5) of subsection (b) of this section, or with a plan or in a program described in subdivision (6) of subsection (b) of this section, may be deemed to be an initial enrollment under subdivisions (1) and (2) of this subsection after the 2-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

(e) **Products to Which Eligible Persons are Entitled** The Medicare supplement policy to which eligible persons are entitled under:

(1) Subdivisions (1), (2), (3) and (4) of subsection (b) of this section is a Medicare supplement

policy which has a benefit package classified as Plan A, B, C, or F (including F with a high deductible), K or L offered by any issuer.

(2) (A) [Subdivision] Subject to subdivision (5) of subsection (b) of this section is (A) the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in subdivision (1) of this subsection[:] ;

(B) After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this subdivision is:

[(B)] (i) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

[(C)] (ii) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer;

(3) Subdivision (6) of subsection (b) of this section shall include any Medicare supplement policy offered by any issuer.

(4) Subsection (b) (7) of this section is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

(f) **Notification provisions**

(1) At the time of an event described in subsection (b) of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (a) of this section. Such notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in subsection (b) of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (a) of this section. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

Sec. 7. Section 38a-495a-10 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 38a-495a-10. Loss ratio standards and refund or credit of premium

(a) **Loss Ratio Standards**

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

(A) At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

(B) At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies; and

(C) The provisions of subparagraphs (A) and (B) of this subsection shall be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health care center on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health care center shall not include:

(i) Home office and overhead costs;

(ii) Advertising costs;

(iii) Commissions and other acquisition costs;

(iv) Taxes;

(v) Capital costs;

(vi) Administrative costs; and

(vii) Claims processing costs.

(2) 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.

(3) For purposes of applying subsection (a)(1) of this section, group policies or certificates issued as a result of solicitations of individuals through the mail or by mass media advertising (including both print and broadcast advertising) shall be deemed to be group policies.

(4) For policies issued prior to the effective date of this section, expected claims in relation to premiums shall meet;

(A) The anticipated loss ratio originally filed with the commissioner as modified to reflect the actual claims experience since the inception of the policy or certificate;

(B) The appropriate loss ratio requirement from subsection (a)(1)(A) or (B) of this section, as applicable, as modified to reflect the actual claims experience during the period beginning on the effective date of this section and ending on the date that the rates and rate schedules are filed with the commissioner; and

(C) The appropriate loss ratio requirement from subsection (a)(1)(A) or (B) of this section, as applicable, over the entire future period for which the rates are computed to provide coverage.

(b) **Refund or Credit Calculation**

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

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

(3) For purposes of this section, for policies issued prior to July 30, 1992, the issuer shall make the refund or credit calculation separately for all individual policies combined and all group policies combined for experience after the effective date of this paragraph. The first report shall be due by May 31, [1998] 2020.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such 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, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(c) **Annual Filing of Premium Rates**

An issuer of Medicare supplement policies and certificates issued before or after July 30, 1992 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 commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. 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 commissioner, in accordance with the applicable filing procedures of this state:

(1) (A) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Such supporting documents as necessary to justify the adjustment shall accompany the filing.

(B) An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such 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.

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

(2) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(d) **Public Hearings**

The commissioner shall conduct a public hearing in accordance with section 38a-474 of the General Statutes to review the request by an issuer for an increase in a rate for a policy form or certificate form issued before or after July 30, 1992.

Sec. 8. Section 38a-495a-13 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 38a-495a-13. Required disclosure provisions

(a) **General Rules**.

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision shall be consistent with the type of contract issued. Such provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any

automatic renewal premium increases based on the policyholder's age.

(2) 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, such premium charge shall be set forth in the policy.

(3) 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.

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

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or 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.

(6) (A) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and Centers for Medicare and Medicaid Services and in a type size no smaller than 12 point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and [acknowledgement] <u>acknowledgment</u> 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.

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

(b) **Notice Requirements**.

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

(A) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate<u>;</u> [,] and [;]

(B) Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

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

(3) Such notices shall not contain or be accompanied by any solicitation.

(c) **MMA Notice Requirements.** Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

(d) **Outline of Coverage Requirements for Medicare Supplement Policies.**

(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an [acknowledgement] acknowledgment of receipt of such outline from the applicant; [,] and [;]

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

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

(3) 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 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.

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

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.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums for policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. (This paragraph shall not appear after June 1, 2011.)

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 our policy, you may return it to (insert issuer's address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

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 response:)

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

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult The Medicare & You 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 regulation. An issuer may use additional benefit plan designations on these charts pursuant to section 38a-495a-6a(d) of the Regulations of Connecticut State Agencies. For purposes of illustration, the charts below display in parentheses dollar amounts that vary in accordance with the Medicare program. Issuers shall revise such dollar amounts as necessary to ensure that outlines of coverage contain information that is current at the time the outlines are provided to consumers.)

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

(*Illustrative charts follow*)

Benefit chart of Medicine Supplement Plans Sold for Effective Dates on or After June 1, 2010

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

Plans E, H, I, and J are no longer available for sale. (This sentence shall not appear after June 1, 2011).

Basic Benefits:

• Hospitalization - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

• Medical Expenses - Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.

• Blood - First three pints of blood each year.

• Hospice - Part A coinsurance.

A	B	C	D	[E] F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B insurance	Hospitalization and preventive care paid at 100%; other	Hospitalization and preventive care paid at 100%; other	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to

A	B	C	D	[E] F	F*	G	K	L	M	N
							basic benefits paid at 50%	basic benefits paid at 75%		$20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit [($4620)] ($5240); paid at 100% after limit reached	Out-of-pocket limit [($2310)] ($2620); paid at 100% after limit reached		

* Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as plan F after one has paid a calendar year ($2000) deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed ($2000). Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's

A	B	C	D	[E] F	F*	G	K	L	M	N
separate foreign travel emergency deductible.										

Benefit Chart of Medicare Supplement Plans Sold On or After January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase plans C, F, and high deductible F. A check mark means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Only Those First Eligible for Medicare Before 2020	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	√	√	√	√	√	√	√	√	√	√
Medicare Part B coinsurance or copayment	√	√	√	√	50%	75%	√	√ copays apply [3]	√	√
Blood (first 3 pints)	√	√	√	√	50%	75%	√	√	√	√
Part A hospice care coinsurance or copayment	√	√	√	√	50%	75%	√	√	√	√
Skilled nursing facility coinsurance			√	√	50%	75%	√	√	√	√
Medicare Part A deductible		√	√	√	50%	75%	50%	√	√	√
Medicare Part									√	√

Benefits	Plans Available to All Applicants								Only Those First Eligible for Medicare Before 2020	
	A	B	D	G[1]	K	L	M	N	C	F[1]
B deductible										
Medicare Part B excess charges				√						√
Foreign travel emergency (up to plan limits)			√	√			√	√	√	√
Out-of-pocket limit in 2018					($5240)[2]	($2620)[2]				

[1]Plans F and G also have a high deductible option which require first paying a plan deductible of $2240 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but **[**$(1,068)**]**$(1,340)	$0	**[**$(1,068)**]**$(1,340) (Part A Deductible)
61st thru 90th day	All but	**[**$(267)**]**$(335) a day	$0

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
	[$(267)]$(335) a day		
91st day and after:			
—While using 60 lifetime reserve days	All but [$(534)]$(670) a day	All but [$(534)]$(670) a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
[21st]21st thru 100th day	All but [$(133.50)]$(167.50) a day	$0	Up to [$(133.50)]$(167.50) a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

Medicare would have paid.

PLAN A

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

*Once you have been billed **[**$135**]**$(183) of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment[,]			
First **[**$(135)**]**$(183) of Medicare Approved Amounts*	$0	$0	**[**$(135)**]**$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next **[**$(135)**]**$(183) of Medicare Approved Amounts*	$0	$0	**[**$(135)**]**$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—tests for diagnostic services	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE Medicare approved services			
—Medically necessary skilled care services and medical	100%	$0	$0

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
supplies			
—Durable medical equipment First [$(135)]$(183) of Medicare Approved Amounts*	$0	$0	[$(135)]$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	$80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$(1,068)]$(1,340)	[$(1,068)]$(1,340) (Part A Deductible)	$0
[61st]61st thru 90th day	All but [$(267)]$(335) a day	[$(267)]$(335) a day	$0
[91st]91st day and after:			
—While using 60 lifetime reserve days	All but [$(534)]$(670) a day	[$(534)]$(670) a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
[21st]21st thru [100th]100th day	All but [$(133.50)]$(167.50) a day	$0	Up to [$(133.50)]$(167.50) a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN B

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

*Once you have been billed [$(135)]$(183) of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment[,]			
First [$(135)]$(183) of Medicare Approved Amounts*	$0	$0	[$(135)]$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	All Costs	$0
Next [$(135)]$(183) of Medicare Approved Amounts*	$0	$0	[$(135)]$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First [$(135)]$(183) of Medicare Approved Amounts*	$0	$0	[$(135)]$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$(1,068)]$(1,340)	[$(1,068)]$(1,340) (Part A Deductible)	$0

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
[61st]61st thru 90th day	All but [$(267)]$(335) a day	[$(267)]$(335) a day	$0
[91st]91st day and after:			
—While using 60 lifetime reserve days	All but [$(534)]$(670) a day	[$(534)]$(670) a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
[21st]21st thru 100th day	All but [$(133.50)]$(167.50) a day	Up to [$(133.50)]$(167.50) a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN C

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

*Once you have been billed **[**$(135)**]**$(183) of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment[,]			
First **[**$(135)**]**$(183) of Medicare Approved Amounts*	$0	**[**$(135)**]**$(183) (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next **[**$(135)**]**$(183) of Medicare Approved Amounts*	$0	**[**$(135)**]**$(183) (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First **[**$(135)**]**$(183) of Medicare Approved Amounts*	$0	**[**$(135)**]**$(183) (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

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OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but **[**$(1,068)**]**$(1,340)	**[**$(1,068)**]**$(1,340) (Part A Deductible)	$0
61st thru 90th day	All but **[**$(267)**]**$(335) a day	**[**$(267)**]**$(335) a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but **[**$(534)**]**$(670) a day	**[**$(534)**]**$(670) a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3			

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
[21st]21st thru 100th day	All but [$(133.50)]$(167.50) a day	Up to [$(133.50)]$(167.50) a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN D

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

*Once you have been billed [$(135)]$(183) of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment[,]			
First [$(135)]$(183) of Medicare Approved Amounts*	$0	$0	[$(135)]$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	All Costs	$0
Next [$(135)]$(183) of Medicare Approved Amounts*	$0	$0	[$(135)]$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First [$(135)]$(183) of Medicare Approved Amounts*	$0	$0	[$(135)]$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

(**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year

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[$(2000)]$(2240) deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$(2000)]$(2240). Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.)

SERVICES	MEDICARE PAYS	(AFTER YOU PAY [$(2000)] $(2240) DEDUCTIBLE,**) PLAN PAYS	(IN ADDITION TO [$(2000)] $(2240) DEDUCTIBLE,**) YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$(1068)] $(1340)	[$(1068)] $(1340) (Part A Deductible)	$0
61st thru [90th]90th day	All but [$(267)]$(335) a day	[$(267)]$(335) a day	$0
91st day and after:			
—While using 60 Lifetime reserve days	All but [$(534)]$(670) a day	[$(534)]$(670) a day	$0
—Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$(133.50)]$(167.50) a day	Up to [$(133.50)]$(167.50) a day	$0
[101st]101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's	All but very limited	Medicare	$0

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SERVICES	MEDICARE PAYS	(AFTER YOU PAY [$(2000)] $(2240) DEDUCTIBLE,**) PLAN PAYS	(IN ADDITION TO [$(2000)] $(2240) DEDUCTIBLE,**) YOU PAY
requirements, including a doctor's certification of terminal illness	copayment/coinsurance for outpatient drugs and inpatient respite care	copayment/coinsurance	

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed **[**$(135)**]**$(183) of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible **[**WILL**]**will have been met for the calendar year.

(**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year **[**$(2000)**]**$(2240) deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are **[**$(2000)**]**$(2240) . Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.)

SERVICES	MEDICARE PAYS	(AFTER YOU PAY [$(2000)] $(2240) DEDUCTIBLE,**) PLAN PAYS	(IN ADDITION TO [$(2000)] $(2240) DEDUCTIBLE,**) YOU PAY
MEDICAL EXPENSES-			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment[,]			
First **[**$(135)**]**$(183) of Medicare Approved Amounts*	$0	**[**$(135)**]**$(183) (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			

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SERVICES	MEDICARE PAYS	(AFTER YOU PAY [$(2000)] $(2240) DEDUCTIBLE,**) PLAN PAYS	(IN ADDITION TO [$(2000)] $(2240) DEDUCTIBLE,**) YOU PAY
First 3 pints	$0	All Costs	$0
Next [$(135)]$(183) of Medicare Approved Amounts*	$0	[$(135)]$(183) (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$(2000)] $(2240) DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [$(2000)] $(2240) DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First [$(135)]$(183) of Medicare Approved Amounts*	$0	[$(135)]$(183) (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$(2000)] $(2240) DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [$(2000)] $(2240) DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE			
Medically necessary emergency care			

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SERVICES	MEDICARE PAYS	AFTER YOU PAY [$(2000)] $(2240) DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [$(2000)] $(2240) DEDUCTIBLE,** YOU PAY
services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G or HIGH DEDUCTIBLE PLAN G

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

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

**(This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $(2240) deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $(2240). Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.)

SERVICES	MEDICARE PAYS	(AFTER YOU PAY $(2240) DEDUCTIBLE,**) PLAN PAYS	(AFTER YOU PAY $(2240) DEDUCTIBLE,**) YOU PAY
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$(1,068)]$(1,340)	[$(1,068)]$(1,340) (Part A Deductible)	$0
61st thru 90th day	All but [$(267)]$(335) a day	[$(267)]$(335) a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but [$(534)]$(670) a day	[$(534)]$(670) a day	$0
—Once lifetime reserve days are used:			
—Additional 365	$0	100% of Medicare	$0***

SERVICES	MEDICARE PAYS	(AFTER YOU PAY $(2240) DEDUCTIBLE,**) PLAN PAYS	(AFTER YOU PAY $(2240) DEDUCTIBLE,**) YOU PAY
days		Eligible Expenses	
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY [CARE *] CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
[21st]21st thru 100th day	All but [$(133.50)]$(167.50) a day	Up to [$(133.50)]$(167.50) a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN G or HIGH DEDUCTIBLE PLAN G

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

*Once you have been billed [$(135)]$(183) of Medicare-Approved amounts for covered services

(which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**(This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $(2240) deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $(2240). Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.)

SERVICES	MEDICARE PAYS	(AFTER YOU PAY $(2240) DEDUCTIBLE,**) PLAN PAYS	(AFTER YOU PAY $(2240) DEDUCTIBLE,**) YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment[,]			
First [$(135)]$(183) of Medicare Approved Amounts*	$0	$0	[$(135)]$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges			
(Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next [$(135)]$(183) of Medicare Approved Amounts*	$0	$0	[$(135)]$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G or HIGH DEDUCTIBLE PLAN G

PARTS A & B

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SERVICES	MEDICARE PAYS	(AFTER YOU PAY $(2240) DEDUCTIBLE,**) PLAN PAYS	(AFTER YOU PAY $(2240) DEDUCTIBLE,**) YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First [$(135)]$(183) of Medicare Approved Amounts*	$0	$0	[$(135)]$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN G or HIGH DEDUCTIBLE PLAN G

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	(AFTER YOU PAY $(2240) DEDUCTIBLE,**) PLAN PAYS	(AFTER YOU PAY $(2240) DEDUCTIBLE,**) YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime [maxi-mum] maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [$(4620)] $(5240) each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends

after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$(1,068)]$(1,340)	[$(534)] $(670) (50% of Part A deductible)	[$(534)] $(670)(50% of Part A deductible)♦
[61st]61st thru 90th	All but [$(267)]$(335) a day	[$(267)]$(335) a day	$0
[day] 91st day and after:			
—While using 60 lifetime reserve days	All but [$(534)]$(670) a day	[$(534)]$(670) a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility [Within] within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
[21st]21st thru 100th day	All but [$(133.50)]$(167.50) a day	Up to [$(66.75)]$(83.75) a day	Up to [$(66.75)]$(83.75) a day ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%♦
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance♦

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
	respite care		

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

PLAN K

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

****Once you have been billed [$(135)]$(183) of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES—			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment[,]			
First [$(135)]$(183) of Medicare Approved Amounts****	$0	$0	[$(135)]$(183) (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved [Amounts] amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges			All costs (and they do not count toward annual out-of-pocket limit of [$(4620)] $(5240))*
(Above Medicare Approved Amounts)	$0	$0	
BLOOD			
First 3 pints	$0	50%	50%♦
Next [$(135)]$(183) of Medicare Approved Amounts****	$0	$0	[$(135)]$(183) (Part B deductible)**** ♦

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to [$(4620)] $(5240) per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service**.

PLAN K

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First **[**$(135)**]**$(183) of Medicare Approved Amounts*****	$0	$0	**[**$(135)**]**$(183) (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	10%	10%♦

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

PLAN L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of **[**$(2310)**]**$(2620) each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$(1,068)]$(1,340)	[$(801)] $(1005) (75% of Part A deductible)	[$(267)] $(335) (25% of Part A deductible) ♦
61st thru 90th day	All but [$(267)]$(335) a day	[$(267)]$(335) a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but [$(534)]$(670) a day	[$(534)]$(670) a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility [Within] within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
[21st]21st thru 100th	All but [$(133.50)]$(167.50) a day	Up to [$(100.13)]$(125.64) (75% of Part A Coinsurance) a day	Up to [$(33.38)]$(41.88) (25% of Part A Coinsurance) a day♦
[day] 101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%♦
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance or copayments	25% of copayment/coinsurance♦

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

PLAN L

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

****Once you have been billed **[**$(135)**]**$(183) of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES—			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment[,]			
First **[**$(135)] $(183)of Medicare Approved Amounts****	$0	$0	**[**$(135)**]** $(183) (Part B deductible****♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
Part B Excess Charges			All costs (and they do not count toward annual out-of-pocket limit of **[**$(2310)**]**$(2620))*
(Above Medicare Approved Amounts)	$0	$0	
BLOOD			
First 3 pints	$0	75%	25%♦
Next **[**$(135)**]**$(183) of Medicare Approved Amounts****	$0	$0	**[**$(135)**]**$(183) (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to [$(2310)]$(2620) per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN L

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First [$(135)]$(183) of Medicare Approved Amounts*****	$0	$0	[$(135)]$(183) (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	15%	5%♦

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

PLAN M

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$(1,068)]$(1,340)	[$(534)]$(670) (50% of Part A deductible)	[$(534)]$(670) (50% of Part A deductible)
61st thru 90th day	All but [$(267)]$(335) a day	[$(267)]$(335) a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but [$(534)]$(670) a day	[$(534)]$(670) a day	$0
—Once lifetime reserve days are used:			

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
[21st]21st thru 100th day	All but **[**$(133.50)**]**$(167.50) a day	Up to **[**$(133.50)**]**$(167.50) a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN M

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

*Once you have been billed **[**$(135)**]**$(183) of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES—			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and			

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment[,]			
First [$(135)]$(183) of Medicare Approved Amounts*	$0	$0	[$(135)]$(183) (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$(135)]$(183) of Medicare Approved Amounts*	$0	$0	[$(135)]$(183) (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN M

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First [$(135)]$(183) of Medicare Approved Amounts*	$0	$0	[$(135)]$(183) (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN M

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
FOREIGN TRAVEL			
NOT COVERED BY MEDICARE Medically necessary emergency care			

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$(1,068)]$(1,340)	[$(1,068)]$(1,340) (Part A Deductible)	$0
[61st]61st thru 90th day	All but [$(267)]$(335) a day	[$(267)]$(335) a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but [$(534)]$(670) a day	[$(534)]$(670) a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
—Beyond the additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
[21st]21st thru 100th day	All but [$(133.50)]$(167.50) a day	Up to [$(133.50)]$(167.50) a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN N

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

*Once you have been billed [$(135)]$(183) of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES—			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment[,]			
First [$(135)]$(183) of Medicare Approved Amounts*	$0	$0	[$(135)]$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $(20) per office visit and up to $(50) per emergency room visit. The	Up to $(20) per office visit and up to $(50) per emergency room visit. The copayment of up to

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
		copayment of up to $(50) is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	$(50) is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges			
(Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next **[**$(135)**]**$(183) of Medicare Approved Amounts*	$0	$0	**[**$(135)**]**$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First **[**$(135)**]**$(183) of Medicare Approved Amounts*	$0	$0	**[**$(135)**]**$(183) (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN N

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
FOREIGN TRAVEL			
NOT COVERED BY			

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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

[(d)] (e) **Notice Regarding Policies or Certificates, Which Are Not Medicare Supplement Policies**.

(1) Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy, a policy issued pursuant to a contract under section 1876 of the Federal Social Security Act (42 U.S.C. [s] section 1395 et seq.), disability income policy[;], or other policy identified in section 38a-495a-1 of the Regulations of Connecticut State Agencies, 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. Such 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.

Such notice shall be in no less than twelve (12) point type and shall contain the following language:

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

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subdivision (1) of this subsection 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.

Sec. 9. Section 38a-495a-21 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 38a-495a-21. Effective date

[This regulation shall be effective on July 30, 1992] Sections 38a-495a-1 to 38a-495a-21, inclusive, of the Regulations of Connecticut State Agencies shall be effective when posted to the eRegulations System website by the Secretary of the State.

Sec. 10. Appendix A to Sections 38a-495a-1 to 38a-495a-21, inclusive, of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. Appendix A.

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE[1] _____ SMSBP[2] _____
For the State of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

line		(a) Earned Premium[3]	(b) Incurred Claims[4]
1	Current Year's Experience a. Total (all policy years) b. Current year's issues[5] 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 Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10	Tolerance Permitted (obtained from credibility table)		

Medicare Supplement 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.

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

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

3 Includes modal loadings and fees charges.

4 Excludes Active Life Reserves.

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

MEDICARE SUPPLEMENT REFUND CALCULATION FORM

FOR CALENDAR YEAR _____

TYPE[1] _____ SMSBP[2] _____
For the State of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

11 Adjustment to Incurred Claims for Credibility
Ratio 3 = Ratio 2 + Tolerance
If ratio 3 is more than benchmark ratio (ratio 1), a refund or credit to premium is not required.
If ratio 3 is less than the benchmark ratio, then proceed.

12 Adjusted Incurred Claims =
(Tot. Earned Premiums (line 3, col a)-Refunds Since Inception (line 6)) x Ratio 3 (line 11)

13 Refund = Total Earned Premiums (line 3, col a)-
Refunds Since Inception (line 6)-
Adjusted Incurred Claims (line 12)
_____
Benchmark Ratio (Ratio 1)

If the amount on line 13 is less than .005 times the annualized premium in force as of the 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.
I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

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

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FOR CALENDAR YEAR _____

TYPE[1] _____ SMSBP[2] _____

FOR THE STATE OF _____ Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____ Person Completing This Exhibit _____

Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
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+[6]		4.175		0.567		8.684		0.838		0.89
Total:		[(k):]	(k):	[(*l*):]	(*l*):	[(m):]	(m):	[(n):]	(n):	

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

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

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

[3]Year 1 is the current calendar year -1

Year 2 is the current calendar year - 2

(etc.)

(Example: If the current year is 1991, then:

Year 1 is 1990. Year 2 is 1989; etc.)

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

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

[6]To include the earned premium for all years prior to as well as the 15th year prior to the current year.

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

TYPE[1] _____ SMSBP[2] _____
FOR THE STATE OF _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing This Exhibit _____
Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.4
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+[6]		4.175		0.493		8.684		0.725		0.77
Total:		[(k):]	(k):	[(*l*):]	(*l*):	[(m):]	(m):	[(n):]	(n):	

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

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

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

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

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

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

[6]To include the earned premium for all years prior to as well as the 15th year prior to the current year.

Sec. 11. Appendix C to Sections 38a-495a-1 to 38a-495a-21, inclusive, of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. APPENDIX C.

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

1. Section 1882(d) of the Federal Social Security Act prohibits the sale of a health insurance policy (the term policy or policies includes certificates) to Medicare beneficiaries that duplicate Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

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

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

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

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

6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

7. The federal law does not preempt state laws that are more stringent than the federal requirements.

8. The federal law does not preempt existing state form filing requirements.

9. Section 1882 of the Federal Social Security Act was amended in subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

(Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only)

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

• hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason

you need them. These include:

• hospitalization
• physician services
• (outpatient prescription drugs if you are enrolled in Medicare Part D)
• other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

(Original disclosure statement for policies that provide benefits for specified limited services)

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

• any of the services covered by the policy are also covered by Medicare

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

• hospitalization
• physician services
• (outpatient prescription drugs if you are enrolled in Medicare Part D)
• other approved items and services

Before You Buy This Insurance

✓ **Check the coverage in all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

(Original disclosure statement for policies that reimburse expenses incurred for specified disease(s) or other specified impairment(s). This includes expense incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.)

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

• hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

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

• hospitalization

• physician services
• hospice care
• (outpatient prescription drugs if you are enrolled in Medicare Part D)
• other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

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

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

This is not Medicare Supplement Insurance

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

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

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

• hospitalization
• physician services
• hospice care
• (outpatient prescription drugs if you are enrolled in Medicare Part D)
• other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

• any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason

you need them. These include:

• hospitalization
• physician services
• (outpatient prescription drugs if you are enrolled in Medicare Part D)
• hospice care
• other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

(Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis)

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

• any expenses or services covered by the policy are also covered by Medicare; or • it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

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

• hospitalization
• physician services
• hospice care
• (outpatient prescription drugs if you are enrolled in Medicare Part D)
• other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

(Original disclosure statement for other health insurance policies not specifically identified in the previous statements)

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

• hospitalization
• physician services
• hospice care
• (outpatient prescription drugs if you are enrolled in Medicare Part D)
• other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

(Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.)

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

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

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

Medicare generally pays for most or all of these expenses.

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

• hospitalization
• physician services
• (outpatient prescription drugs if you are enrolled in Medicare Part D)
• other approved items and services

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

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

(Alternative disclosure statement for policies that provide benefits for specified limited services.)

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

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

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

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

• hospitalization
• physician services
• (outpatient prescription drugs if you are enrolled in Medicare Part D)
• other approved items and services

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

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

(Alternative disclosure statement for policies that reimburse expenses incurred for specified disease(s) or other specified impairment(s). This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.)

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

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

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

Medicare generally pays for most or all of these expenses.

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

• hospitalization
• physician services
• hospice care
• (outpatient prescription drugs if you are enrolled in Medicare Part D)
• other approved items and services

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

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

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

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

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

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions,

for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

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

• hospitalization
• physician services
• hospice care
• (outpatient prescription drugs if you are enrolled in Medicare Part D)
• other approved items and services

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

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

(Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.)

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

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

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

Medicare generally pays for most or all of these expenses.

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

• hospitalization
• physician services
• hospice care
• (outpatient prescription drugs if you are enrolled in Medicare Part D)
• other approved items and services

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

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

(Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis)

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

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

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

Medicare generally pays for most or all of these expenses.

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

• hospitalization
• physician services
• hospice care
• (outpatient prescription drugs if you are enrolled in Medicare Part D)
• other approved items and services

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

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

(Alternative disclosure statement for other health insurance policies not specifically identified in the previous statements)

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

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

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

Medicare generally pays for most or all of these expenses.

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

• hospitalization
• physician services
• hospice care
• (outpatient prescription drugs if you are enrolled in Medicare Part D)
• other approved items and services

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

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Statement of Purpose

The purpose of this proposed regulation is to conform the Medicare Supplement regulations to the newest version of the NAIC model regulation. These changes were necessary due to changes in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) that required conformity from our state regulations. Other changes included in these regulations include stylistic changes to move closer to conformity with the NAIC model act.

Form Agency-Cert-PR-TR-ICM (NEW 6/2015)
State of Connecticut
Secretary of the State

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IMPORTANT NOTICE FOR CONNECTICUT STATE AGENCIES
This form is to be used for proposed permanent and technical amendment regulations only and must be completed in full.

AGENCY CERTIFICATION

Insurance Department

Proposed Regulation Concerning

Medicare Supplement Insurance Regulation

eRegulations System Tracking Number **PR2018-021**

I hereby certify the following:

(1) The above-referenced **regulation** is proposed pursuant to the following statutory authority or authorities: **CGS Sections 38a-495 and 38a-495a**

For technical amendment regulations proposed without a comment period, complete #2 below, then skip to #8.

(2) As permitted by Section 4-168(h) of the *Connecticut General Statutes*, the agency elected to proceed without prior notice or hearing and posted the text of the proposed technical amendment regulation on eRegulations System website on .

For all other non-emergency proposed regulations, complete #3 - #7 below, then complete #8)

(3) The agency posted notice of intent with a specified comment period of not less than 30 days to the eRegulations System website on **October 18, 2018**.

(4) *(Complete one)* ☒ No public hearing held or was required to be held. **OR** ☐ One or more public hearings were held on: **<<select and enter dates>>**.

(5) The agency posted notice of decision to move forward with the proposed regulation to the eRegulations System website on **November 26, 2018**.

(6) *(Complete one)* ☐ No comments were received. **OR** ☒ Comments were received and the agency posted the statements specified in subdivisions (2) and (3) of CGS Section 4-168(e) to the eRegulations System website on **November 21, 2018**.

(7) The final wording of the proposed regulation was posted to the eRegulations System website on **February 13, 2019**.

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(8) Subsequent to approval for legal sufficiency by the Attorney General and approval by the Legislative Regulation Review Committee, **the final regulation shall be effective**

(Check one and complete as applicable)

☒ When posted to the eRegulations System website by the Secretary of the State.

OR ☐ On _____
(Date must be a specific calendar date not less than 11 days after submission to the Secretary of the State)

SIGNED *(Head of Board, Agency or Commission, or duly authorized deputy)*	**Acting Commissioner** OFFICIAL TITLE	**2/13/19** DATE

Connecticut eRegulations System — Tracking Number PR2018-021 — Posted 2/15/2019

OFFICE OF THE ATTORNEY GENERAL
REGULATION CERTIFICATION

Agency: Connecticut Insurance Department

***REGULATION NUMBER* PR2018-021**

This Regulation is hereby APPROVED by the Attorney General as to legal sufficiency in accordance with Connecticut General Statutes Section 4-169.

DATE: 2/15/2019

Signed: _____

Joseph Rubin, Assistant Deputy Attorney General
Duly Authorized

eRegulations.ct.gov

The Connecticut General Assembly

Legislative Regulation Review Committee

Senator Craig Miner
Senate Chair

Representative Susan Johnson
House Chair

Official Record of Committee Action

March 26, 2019

Agency:	Insurance Department
Description:	Medicare Supplement Insurance
LRRC Regulation Number:	2018-028A
eRegulation Tracking Number:	PR2018-021

The above-referenced regulation has been

Approved with Technical Corrections

by the Legislative Regulation Review Committee in accordance with CGS Section 4-170.

Kirstin L. Breiner
Committee Administrator

eRegulations.ct.gov

State of Connecticut
Office of the Secretary of the State

Confirmation of Electronic Submission

Re: Regulation of the Insurance Department concerning Medicare Supplement Insurance
eRegulations System Tracking Number PR2018-021
Legislative Regulation Review Committee Docket Number 2018-028A

The above-referenced regulation was electronically submitted to the Office of the Secretary of the State in accordance with Connecticut General Statutes Section 4-172 on March 29, 2019.

Said regulation is assigned Secretary of the State File Number 6292.

The effective date of this regulation is April 4, 2019.

Denise W. Merrill
Secretary of the State
April 4, 2019

By:

/s/ Kristin M. Karr
Kristin M. Karr
Administrative Law
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