NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* first as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council or the Attorney General. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 20. BOARD OF DISPENSING OPTICIANS

[R05-347]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

Article 1	Amend
R4-20-101	Amend
R4-20-102	Amend
R4-20-103	Amend
R4-20-104	Amend
R4-20-105	Amend
R4-20-106	Amend
R4-20-107	Amend
R4-20-109	Amend
R4-20-110	Amend
R4-20-111	Amend
R4-20-112	Amend
R4-20-113	Amend
R4-20-114	Amend
R4-20-115	Amend
R4-20-116	Amend
R4-20-117	Amend
R4-20-118	Amend
R4-20-119	Amend
R4-20-120	Amend
R4-20-121	Amend
R4-20-122	New Section
R4-20-123	New Section
R4-20-124	New Section
R4-20-125	New Section
R4-20-126	New Section
Table 1	Amend

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 32-1673 and 32-1685

Implementing statutes: A.R.S. §§ 32-1671, 32-1672, 32-1673, 32-1674, 32-1681, 32-1682, 32-1683, 32-1684, 32-1684.01, 32-1685, 32-1686, 32-1687, 32-1691, 32-1691.01, 32-1693, 32-1694, 32-1695, 32-1695, 32-1696, 32-1697, 32-1698, and 32-1699

3. The effective date of the rules:

November 15, 2005

4. A list of all previous notices appearing in the *Register* addressing the final rule:

Notice of Rulemaking Docket Opening: 10 A.A.R. 2320, June 11, 2004

Notice of Proposed Rulemaking: 10 A.A.R. 4526, November 12, 2004

Notice of Supplemental Proposed Rulemaking: 11 A.A.R. 782, February 18, 2005

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name:	Lori D. Scott, Executive Director
Address:	1400 W. Washington, Rm 230 Phoenix, AZ 85007
Telephone:	(602) 542-3095
Fax:	(602) 542-3093
E-mail:	director@asbdo.state.az.us

6. An explanation of the rule, including the agency's reason for initiating the rule:

The rules provide detailed licensing and regulatory information and procedural instructions for dispensing opticians. The Board is amending the proposed rules for clerical clarification and to provide consistency with the rules. R4-20-104 was amended to remove the requirement for a written examination as the Board no longer administers a written examination. The Board requires passage of the national American Board of Opticianry and National Contact Lens Examiners examinations. The Board is also adding fees to the rules. These fees include late changes for submitting renewal applications late and charges for Board records and documentation. A supplemental proposed rulemaking was published because of comments made after the Notice of Proposed Rulemaking was published. Changes previously made to the scope of opticianry were removed due to consideration of comments made by the public.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

None

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

A. Identification of proposed rulemaking

Changes in rules R4-20-101 through R4-20-121 consist of clarification of rules for better understanding. R4-20-106 (C) currently allows an applicant who fails to pass the practical examination to re-take the examination at either of the next two scheduled examinations without payment of any additional fees. This change in this rulemaking will require an applicant who fails the practical examination to re-apply as an original applicant and submit an application and fee each time to re-take the practical examination. Rules R4-20-122 through R4-20-126 are added to further define the rulemaking process within the agency.

B. Identification of those affected by the rulemaking

Those affected will be the Board, applicants, dispensing opticians, consumers of dispensing optician services, and owners of optical establishments. The primary beneficiaries of the rules are the persons to whom the services are being provided.

C. Summary of the economic, small business and consumer impact statement

Annual cost/revenues are designated as minimal when less than $1,000, moderate when between $1,000 and $10,000, and substantial when greater than $10,000. The Board anticipates minimal to no impact on dispensing opticians, consumers of dispensing optician services, and owners of optical establishments with the amendments proposed. The costs to the Board are moderate for promulgation of the rules. The Board's administrative and staff costs to implement the rules are minimal. The Secretary of State's cost for publishing the rules is minimal. The cost for review of the rules by the Governor's Regulatory Review Council is minimal. The cost of licensed opticians and establishments to review new rules is minimal. There will be minimal cost for an individual applying for a license or license issuance. A licensee may choose to pass the cost on to consumers.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

R4-20-117 was changed to clarify the parameters of the scope of opticianry. Upon further review and comments made to the Board, the Board decided not to include this expanded scope and leave it as is. R4-20-126 was deleted as this no longer necessary. Subsequent sections were re-numbered. All other changes are to clarify the rules. Incorporated ANSI standard Z80.3-1998 was deleted as this was incorrect information. The 1998 edition does not exist for this standard.

11. A summary of the comments made regarding the rule and the agency response to them:

None

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

13. Incorporations by reference and their location in the rules:

R4-20-119(B).

ANSI Z80.1-1999, "Prescription Ophthalmic Lenses-Recommendations."

ANSI Z80.20-1998, "Contact Lenses- Standard Terminology, Tolerances, Measurements and Physiochemical Properties."

ANSI Z80.5-2004, "Requirements for Ophthalmic Frames."

ANSI Z87.1-2003, "Occupational and Educational Personal Eye and Face Protection Devices."

ANSI Z80.9-1998 "Optical Devices for Low Vision."

14. Was this rule previously made as an emergency rule?

No.

15. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 20. BOARD OF DISPENSING OPTICIANS

ARTICLE 1. ~~IN~~ GENERAL

Section

ARTICLE 1. ~~IN~~ GENERAL

R4-20-101. Definitions

The following definitions apply in this Chapter unless otherwise specified:

1. "ABO" means the American Board of Opticianry.
2. "Applicant" means an individual requesting an initial or renewal license from the Board.

3. "Application packet" means the forms and additional information the Board requires to be submitted by an applicant or on the applicant's behalf.
4. "Comity" means the procedure for granting an Arizona license to an applicant who is already licensed as a dispensing optician in another state of the United States.
5. "Days" means calendar days.
6. "Laboratory experience" means work directly involved in the process of producing optical devices and does not include work that is strictly clerical.
7. "License" means a written authorization issued by the Board to practice as a dispensing optician or operate an optical establishment in Arizona.
8. "NCLE" means the National Contact Lens Examiners.
9. "Nationally recognized body of opticianry accreditation" means the Commission on Opticianry Accreditation.
10. "Optical devices" means eyeglasses, contact lenses, prosthetic eyes, low-vision aids, other eyewear, ~~or~~ and eyewear appurtenances or parts.
11. "Optometrist" means a person currently licensed in any state of the United States in the practice of the profession of optometry as defined in A.R.S. § 32-1701 ~~in any state of the United States~~.
12. "Physician" means a ~~doctor~~ person currently licensed in any state of the United States to practice allopathic or osteopathic medicine ~~in any state of the United States~~.
13. ~~"Vision practitioner" means a physician licensed in Arizona~~.
14. "Work week" means the period of time beginning on Sunday at 12:00 a.m. and ending the following Saturday at 11:59 p.m.

R4-20-102. Application for a Dispensing Optician's License by Examination

At least 45 days before an examination date, an applicant for a dispensing optician's license by examination shall submit to the Board an application packet that contains:

1. An application form provided by the Board, signed and dated by the applicant, and notarized that contains:
   a. The applicant's name, Social Security ~~social security~~ number, address, and telephone number;
   b. The name and address of the applicant's employer at the time of application, if applicable;
   c. If demonstrating technical skill and training under A.R.S. § 32-1683(5)(b), the name and address of each dispensing optician, physician, or optometrist for whom the applicant served as an apprentice for ~~3~~ three of the ~~6~~ six years immediately preceding the application date, and the ~~1st~~ beginning and ~~last e~~nding dates of each apprenticeship;
   d. If demonstrating technical skill and training under A.R.S. § 32-1683(5)(c), the name and address of the school from which the applicant graduated, dates of attendance, date of graduation, degree received, and the name and address of each dispensing optician for whom the applicant served as a dispensing optician apprentice for ~~1~~ one of the ~~6~~ six years immediately preceding the application date and the ~~1st~~ beginning and ~~last~~ ending dates of service. The applicant shall submit a photocopy of ~~a~~ the applicant's diploma from the optical dispensing school;
   e. If demonstrating technical skill and training under A.R.S. § 32-1683(5)(d), the name and address of each dispensing optician, physician, or optometrist for whom the applicant has worked for ~~3~~ three of the ~~6~~ six years immediately preceding the application date and the ~~first~~ beginning and ~~last~~ ending dates of employment;
   f. A statement of whether the applicant has ever been convicted of a felony or of a misdemeanor involving moral turpitude in any state;
   g. A statement of whether the applicant has ever ~~been denied~~ had an application for a professional license denied or had a license suspended or revoked in any state; and
   h. A sworn statement by the applicant verifying the truthfulness of the information provided by the applicant;
2. A photocopy of the applicant's high school diploma or general educational diploma issued in any state;
3. Verification of passing ~~a~~ an ABO and NCLE ~~national~~ Board examination in opticianry as evidenced by an original notice of examination results or original certificate of ~~successful~~ passage issued by the ~~professional examination service~~ organization that prepared the examination;
4. A letter attesting to good moral character from each of ~~3~~ three individuals who are not family members, who have known the applicant for ~~2~~ two years immediately ~~preceding~~ before the date of the application, and support the applicant's licensure;
5. A letter from each ~~ophthalmologist~~ physician, optometrist, or dispensing optician named in subsection (1)(c),(d), or (e) ~~licensed in any state who provided direct supervision to the applicant during the applicant's apprenticeship~~ that contains:
   a. The individual's printed name, address, and telephone number; and
   b. A statement that the applicant has either served as an apprentice or been employed as a dispensing optician by the ~~ophthalmologist~~ physician, optometrist, or dispensing optician for the time required in subsection ~~subsections (A)~~(1)(c),(d), or (e). ~~If the applicant served as an apprentice or was employed as a dispensing optician by more than 1 ophthalmologist, optometrist, or dispensing optician, the applicant shall submit a letter from each ophthalmologist, optometrist, or dispensing optician for whom the applicant is claiming experience.~~

6. A ~~passport~~ photograph of the applicant no ~~larger~~ smaller than 1 ½ x 2 inches and taken not more than ~~6~~ six months before the date of application; and
7. The fee required in R4-20-112.

R4-20-103. Approval to Take Dispensing Optician Examination ~~take dispensing optician examination~~

A. An applicant shall file an application to take the dispensing optician license examination ~~shall be received by~~ with the Board 45 days ~~prior to~~ before the date of the examination.

~~C.~~B. The Board may reduce or waive the 45-day requirement for any portion of the application if its nonavailability is outside the applicant's control.

~~B.~~C. The Board shall notify an applicant ~~Applicants~~ whose application ~~has been~~ is approved ~~shall be notified prior to~~ before the date of the examination as to the time and place of the examination.

R4-20-104. Dispensing Optician Practical ~~Examinations~~ Examination

A. At least twice each year, the Board shall administer a dispensing optician practical examination. The Board shall not space the examinations more than ~~8~~ eight months apart.

B. ~~A written dispensing optician examination shall cover the following subjects:~~
1. ~~Ocular anatomy,~~
2. ~~Geometric optics and laboratory,~~
3. ~~Ophthalmic dispensing, and~~
4. ~~Contact lenses.~~

~~C.~~ The practical examination shall include measurement of optical devices, interpupillary distance, segment heights, corneal curvature, and the identification of lens styles and tints. An applicant shall use only ~~Only~~ Board-supplied measuring equipment and optical devices ~~shall be used~~ in the practical examination.

~~D.~~ ~~An individual who obtained a passing score on a dispensing optician examination administered by the ABO and holds a current certificate issued by the ABO, may substitute the dispensing optician examination for those portions of the examination required in subsections (B)(1), (B)(2), and (B)(3), by submitting to the Board a current ABO certificate that states ABO requirements have been met and by:~~
1. ~~Submitting to the Board the original notice of examination results or the original certificate that states the individual passed the examination; or.~~
2. ~~Having the ABO submit directly to the Board a notice of examination results or certificate of passing the examination.~~

~~E.~~ ~~An individual who obtained a passing score on a contact lens examination administered by the NCLE, and holds a current certificate issued by the NCLE may substitute that examination for those portions of the examination required in subsection B(4), by submitting to the Board a current NCLE certificate that states NCLE requirements have been met and by:~~
1. ~~Submitting the original notice of examination results or the original certificate that states the individual passed the examination; or~~
2. ~~Having the NCLE submit directly to the Board a notice of examination results or certificate of passing the examination.~~

R4-20-105. Practical Examination Procedures

~~A.~~ ~~The Board's method of administering the written portion of an examination shall be for the applicant to apply to the American Board of Opticianry and National Contact Lens Examiners and successfully complete those examinations. Rules of the testing service shall apply.~~

~~B.~~A. For the practical examination, an applicant shall not bring books or notes into the examination room, communicate by any means with other applicants while the examination is in progress~~,~~ unless expressly authorized by the presiding examiner, or leave the examination room without first securing the presiding examiner's permission. ~~Violation of this subsection shall terminate the applicant's right to continue the examination.~~ If an applicant violates this subsection, the presiding examiner shall confiscate the examination answer sheet and the Board shall not allow the applicant to complete the examination.

~~C.~~B. For the practical examination, ~~no persons except~~ only applicants, Board members, employees of the Board ~~or~~ and persons having the express permission of the Board ~~shall be~~ are permitted in the examination room while the examination is in progress.

~~D.~~C. ~~The examination~~ Examination papers are the property of the Board, ~~and~~ The Board shall ~~will~~ not ~~be returned~~ return examination papers to the applicant.

R4-20-106. Scoring of Examination; Failure to Pass

A. To pass, an applicant shall achieve a grade of 75% or more ~~shall be achieved~~ on the practical examination. For the written ~~subjects~~ examination, the applicant ~~must meet the passing~~ shall achieve a grade of 70% or more on the ABO ~~American Board of Opticianry~~ examination and ~~must meet the passing~~ shall achieve a grade of 72% or more on the NCLE ~~National Contact Lens Examiners~~ examination.

B. ~~Failure to pass an examination shall not preclude an applicant from participation in a subsequent examination.~~

~~C.~~ An applicant who fails to pass the practical examination ~~may re-take the practical examination at either of the next two scheduled examinations without the payment of any additional fee~~ shall re-apply as an original applicant as described in R4-20-102.

~~D. After the second failure of the practical examination, re-examination will be permitted only after filing a second application and payment of the fee for re-application.~~

R4-20-107. Application for a Dispensing Optician's License by Comity

An applicant for a dispensing optician's license by comity shall submit an application packet to the Board that contains:

1. An application form provided by the Board, signed and dated by the applicant, and notarized that contains:
   a. The applicant's name, Social Security ~~social security~~ number, address, and telephone number;
   b. The applicant's dispensing optician license number and the state and date of licensure;
   c. A statement of whether the applicant has ever been convicted of a felony or of a misdemeanor involving moral turpitude in any state;
   d. A statement of whether the applicant has ever been denied ~~an application~~ a license or had a license suspended or revoked in any state; and
   e. A sworn statement by the applicant verifying the truthfulness of the information provided by the applicant;
2. A photocopy of the unexpired license and a written statement, signed by an officer of the ~~licensing~~ Board that issued the license, that states the license is in good standing, and that the license is valid to dispense both eyeglasses and contact lenses;
3. A photograph of the applicant no ~~larger~~ smaller than 1 ½ x 2 inches and taken not more than ~~6~~ six months before the date of application; and
4. The fee required in R4-20-112.

R4-20-109. Renewal of Dispensing Optician's License; Late Renewal; Reinstatement

A. No later than December 31 of each year, an applicant for renewal of a dispensing optician's license shall submit to the Board the fee required by R4-20-112, proof of continuing education credits required by R4-20-120, and an application form, provided by the Board, signed and dated by the applicant, and notarized that contains:
1. The applicant's name, Social Security number, address, and telephone number;
2. The name, address, telephone number, and Arizona license number of the optical establishment at which the applicant is currently practicing as a dispensing optician; and
3. A statement that the information contained on the renewal application is ~~true and~~ correct.

B. A licensee who submits a renewal application and renewal fee postmarked after December 31 but before January 31 of the following year shall pay the late fee in R4-20-112.

C. A licensee who fails to submit a renewal application postmarked before January 31 following a license expiration of December 31, and who wishes to reinstate the license, shall:
1. Submit a reinstatement application within one year of license expiration;
2. Pay the renewal fee and the late fee in R4-20-112;
3. Achieve a passing grade on the practical examination, unless the applicant has successfully completed the practical examination in the five-year period immediately preceding the license expiration; and
4. Submit evidence of passing the ABO and NCLE examinations.

R4-20-110. Application for an Optical Establishment License

An applicant for an optical establishment license shall submit an application packet to the Board that contains:

1. An application form provided by the Board, signed and dated by the applicant, and notarized that contains:
   a. The applicant's name, establishment name, establishment address, and telephone number. An application form shall be signed by the following:
      i. If a sole proprietorship, the individual owning the optical establishment;
      ii. If a corporation, each individual owning 20% or more of the voting stock in the corporation;
      iii. If a partnership, the managing partner and a general partner;
      iv. If a limited liability company, the designated manager, or if no manager is designated, any ~~2~~ two members of the limited liability company;
   b. The hours the establishment will be open to the public for business;
   c. If applicable, the name, business address, and telephone number of each licensed optical establishment currently being operated by the applicant in Arizona;
   d. If a corporation, the name of the statutory agent, the corporation's officers, and the state of incorporation; and
   e. The name, business address, telephone number, and license number of each licensed dispensing optician who is scheduled to work at the establishment on a full-time basis, consisting of ~~for~~ 32 hours or more per week;
2. If a corporation, the articles of incorporation; and
3. The fee required in R4-20-112.

R4-20-111. Time-frames for License Approvals

A. The overall time-frame described in A.R.S. § 41-1072(2) for each type of approval granted by the Board is set forth in Table 1. The applicant and the Executive Director of the Board may agree in writing to extend the substantive review and overall time-frame. The substantive review time-frame may not be extended by more than 25% of the overall time-frame.

B. The administrative completeness review time-frame described in A.R.S. § 41-1072(1) for each type of approval granted by the Board is set forth in Table 1.

1. The administrative completeness review time-frame begins:
   a. For approval to take a dispensing optician examination or for an optical establishment license, when the Board receives an application packet.
   b. For approval or denial of a license by examination ~~or license by comity,~~ when the applicant takes the dispensing optician examination.
   c. For a license by comity, when the Board receives an application packet.
2. If the application packet is incomplete, the Board shall send to the applicant a written notice specifying the missing document or incomplete information. The administrative completeness review time-frame and the overall time-frame are suspended from the postmark date of the notice until the date the Board receives a complete application packet from the applicant.
3. If an application packet is complete, the Board shall send a written notice of administrative completeness to the applicant.
4. If the Board grants a license or approval during the time provided to assess administrative completeness, the Board shall not issue a separate written notice of administrative completeness.

C. The substantive review time-frame described in A.R.S. § 41-1072(3) is set forth in Table 1 and begins on the postmark date of the notice of administrative completeness.

1. During the substantive review time-frame, the Board may make ~~a~~ one comprehensive written request for additional information or documentation. The time-frame for the Board to complete the substantive review is suspended from the postmark date of the comprehensive written request for additional information or documentation until the Board receives the additional information or documentation.
2. The Board shall send a written notice approving the applicant ~~A.R.S. §§ 32-1681 through 32-1687~~ to take an examination or granting a license to an applicant who meets the qualifications in A.R.S.§§32-1681 through ~~32-1687~~ 32-1684 and 32-1687.
3. The Board shall send a written notice of denial to an applicant who fails to meet the qualifications in A.R.S.§§32-1681 through ~~32-1687~~ 32-1684 and 32-1687.

D. The Board shall consider an application withdrawn if within 360 days from the application submission date the applicant fails to:

1. Supply the missing information under subsection (B)(2) or (C)(1); or
2. Take the dispensing optician examination.

E. An applicant who does not ~~wish~~ want an application withdrawn may request a denial in writing within 360 days from the application submission date.

F. If a time-frame's last day falls on a Saturday, Sunday, or an official state holiday, the next business day shall be considered the time-frame's last day.

R4-20-112. Fees

A. Dispensing optician fees, which are non-refundable unless A.R.S. § 41-1077 applies, are as follows:

1. License application fee: $100
2. License issuance fee: $100
3. Renewal of dispensing optician license: $135
4. License renewal late fee: $100

B. Optical establishment license fees are as follows:

1. License application fee: $100
2. License issuance fee: $100
3. Renewal of optical establishment license: $135
4. License renewal late fee: $100

C. Fees for copies of public records are:

1. Duplicate optician license: $25
2. Duplicate establishment license: $25
3. Dispensing Optician Statutes and rules: $10
4. Directories:
   a. Commercial use: $2.50 per page
   b. Non-commercial use: $1.00 per page
5. Labels:
   a. Commercial use: $ .30 per name

b. Non-commercial use: $ .10 per name
6. All other records: $ .50 per page

R4-20-113. Display of Licenses; Nontransferability ~~licenses, nontransferability~~

A. A licensee shall display ~~All~~ all licenses~~, including temporary licenses, shall be displayed~~ in ~~public view~~ in a conspicuous place. If a license is ~~has been~~ renewed, the licensee shall display the evidence of renewal ~~or copy thereof must be displayed with the license~~ in public view.

B. Optical establishment and dispensing optician licenses are not transferable.

C. A licensee shall return an ~~Optical~~ optical establishment license ~~licenses shall be~~ ~~returned~~ to the Board upon transfer of ownership or going out of business.

R4-20-114. Notice of Change of Status ~~change of status~~

A. An ~~Optical~~ optical establishment licensee ~~licensees~~ and dispensing optician licensee ~~licensees~~ shall notify the Board of any change in the information provided to the Board concerning license application or its renewal, including any change ~~changes~~ in name, address, work location, establishment ownership ~~and~~ or the name, address ~~and~~ or home telephone number of each dispensing optician ~~opticians, optometrists or vision~~ ~~practitioners~~ working at the establishment.

B. This notice shall be in writing and made within 30 ~~thirty~~ days of change of status.

C. For purposes of this Section, a change of establishment ownership means:
1. The transfer of a controlling interest in the optical establishment business from one person to another;
2. The addition or termination of a general partner; or
3. The transfer or agreement to transfer a block of twenty percent or more of the outstanding voting stock of a corporation or association or the transfer or agreement to transfer any amount of voting stock ~~which~~ that would give the transferee control of a majority of ~~its~~ outstanding voting stock. For purposes of this paragraph, "voting stock" ~~includes~~ means any interest or system whereby the operation of a corporation is controlled by its owners or trustees.

R4-20-115. Renewal of Optical Establishment License; Late Renewal; Re-application

A. No later than June 30 of each year, an applicant for renewal of an optical establishment license shall submit to the Board the fee required by R4-20-112 and an application form, provided by the Board that contains:
1. The name, address, and telephone number of the optical establishment;
2. The name and license number of each dispensing optician who is scheduled to work 32 hours or more each ~~work~~ week at the optical establishment; and
3. The applicant's signature and title.

B. A licensee who submits a renewal application and renewal fee postmarked after June 30 but before July 31 of the renewal year shall pay the late fee in R4-20-112.

C. A licensee who fails to submit a renewal application postmarked before July 31 following a license expiration of June 30, and who wishes to re-apply for an establishment license, shall submit an original application, and pay the application fee and license fee in R4-20-112.

R4-20-116. Rehearing or Review of Decision

A. Except as provided in subsection (G), ~~any~~ a party in a contested case before the Board who is aggrieved by a decision rendered in ~~such~~ the case may file with the Board not later than ~~ten~~ 30 days after service of the decision, a written motion for rehearing or review of the decision specifying the particular grounds ~~therefore~~ for the rehearing or review. For purposes of this Subsection a decision ~~shall be~~ is deemed to ~~have been~~ be served when personally delivered or mailed by certified mail to the party at ~~his~~ the party's last known residence or place of business.

B. A party may amend a motion for rehearing or review ~~under this Section may be amended~~ at any time before it is ruled upon by the Board. Any other party may file a response ~~may be filed~~ within ~~ten~~ 15 days after service of ~~such~~ the motion or amended motion ~~by any other party~~. The Board may require the filing of written brief upon the issues raised in the motion and may provide for oral argument.

C. A rehearing or review of the decision may be granted for any of the following causes materially affecting the moving party's rights:
1. Irregularity in the administrative proceedings of the Board, the Board's ~~or its~~ informal interviewing officer, or the prevailing party, or any order or abuse of discretion that deprived ~~whereby~~ the moving party ~~was deprived~~ of a fair hearing or interview;
2. Misconduct of the Board or the prevailing party;
3. Accident or surprise ~~which~~ that could not have been prevented by ordinary prudence;
4. Newly discovered material evidence ~~which~~ that could not with reasonable diligence have been discovered and produced at the original hearing;
5. Excessive or insufficient penalties;
6. Error in the admission or rejection of evidence or other errors of law occurring at the administrative hearing; or
7. ~~That the~~ The decision is not justified by the evidence or is contrary to law.

D. The Board may affirm or modify the decision or grant a rehearing or review to all or any of the parties and on all or part of

the issues for any of the reasons ~~set forth~~ in subsection (C). An order granting a rehearing or review shall specify with particularity the ~~ground or~~ grounds on which the rehearing or review is granted, and the rehearing or review shall cover only those matters ~~so~~ specified.

E. Not later than ~~ten~~ 10 days after a decision is rendered, the Board may on its own initiative order a rehearing or review of its decision for any reason for which the Board ~~it~~ might have granted a rehearing or review on motion of a party. After giving the parties or ~~their~~ the parties' counsel notice and an opportunity to be heard on the matter, the Board may grant a motion for rehearing or review for a reason not stated in the motion. ~~Any order granting such a rehearing or review shall specify the grounds therefor.~~

F. When a motion for rehearing or review is based upon affidavits, ~~they~~ the moving party shall ~~be served~~ serve the affidavits with the motion. An opposing party may within ~~ten~~ 10 days after ~~such~~ service, serve opposing affidavits. ~~That period may be extended~~ The Board may extend the period for an additional ~~period not exceeding~~ ~~twenty~~ 20 days ~~by the Board~~ for good cause shown or by written stipulation of the parties. The Board may permit reply affidavits ~~may be permitted.~~

G. If in a ~~particular~~ decision the Board makes specific findings that the immediate effectiveness of ~~such~~ the decision is necessary for the immediate preservation of the public peace, health, ~~and~~ or safety and that a rehearing or review of the decision is impracticable, unnecessary, or contrary to the public interest, the Board may issue the decision ~~may be issued~~ as a final decision without an opportunity for ~~a~~ rehearing or review. If a decision is issued as a final decision without an opportunity for rehearing or review, a party shall make ~~any~~ application for judicial review of the decision ~~shall be made~~ within the time limits permitted for applications for judicial review of the Board's final decisions.

H. For purposes of this Section the terms "contested case" and "party" have the same meaning as in A.R.S.§~~31-1671(3)~~ 41-1001 and "appealable agency action" has the same meaning as in A.R.S. § 41-1092.

R4-20-117. Scope of Practice ~~practice~~

The scope of practice of a dispensing optician means the ~~includes those~~ activities described in A.R.S. §32-1671(3).

R4-20-118. Unprofessional Conduct

In addition to actions specified in A.R.S. §32-1696, unprofessional conduct in the practice of optical dispensing includes the following:

1. Substandard care as specified in R4-20-119;
2. Failing to maintain a copy of the customer's prescription or failing to prepare and maintain a record of ~~the~~ optical devices ~~actually~~ dispensed for ~~a minimum period of~~ at least three years. The record shall include the brand, style and size of the frame, if any, and the style, material, and all other information necessary to accurately reproduce each lens. The ~~All such~~ records shall be separate from ~~Arizona state licensed~~ optometrists' or physicians' records~~.~~;
3. Failing or refusing to make a copy of a record described in ~~Paragraph~~ subsection (2) promptly available to the customer, who is the subject of the record, the customer's designated representative, the customer's prescribing practitioner, or the Board or its investigator, when requested. Notwithstanding this provision, a dispensing optician need not make the record of contact lenses dispensed on a trial basis available to the customer ~~until the trial period has ended or a period of 60 days has elapsed without the dispensing of a retrial lens.~~; and
4. Failing or refusing to take corrective action or investigate a customer complaint concerning the manufacture or fit of eyeglasses, contact lenses, or other optical devices dispensed at the establishment by which the dispensing optician is employed if there is a substantial basis for the complaint.

R4-20-119. Substandard Care

A. It is substandard care for a dispensing optician:

1. To dispense improperly manufactured eyeglasses or contact lenses ~~which are the subject of a complaint filed with the Board under A.R.S.§32-1691.01(B)~~. If ~~the~~ a complaint indicates that eyeglasses or contact lenses dispensed by a dispensing optician or other employee of an optical establishment may have been improperly manufactured, the Board shall be guided in its determination of the facts by referring to the standards ~~specified~~ incorporated by reference in subsection (B) with regard to the individual parameters listed in the standards and considering patient wear, care, and usage~~.~~;
2. When interpreting written prescriptions, to fail to follow ~~industry standards specified~~ standards incorporated by reference in subsection (B) in determining lens powers due to differences in vertex distances, base curvatures, special lens requirements, and facial fitting problems, or to fail to comply with special instructions of the vision practitioner or optometrist shown on the prescription without the full knowledge and consent of the customer, the ~~vision practitioner~~ physician, or optometrist~~.~~;
3. To fail to follow manufacturer's guidelines regarding usual and customary lens thickness of eyewear~~.~~;
4. To intentionally or negligently injure a customer during the course of optical dispensing~~.~~; or
5. To fail to give the customer appropriate instructions on the care, handling, and wearing of ~~the~~ an optical device ~~devices~~.

B. The following standards published by the American National Standards Institute, Inc., (ANSI), 1819 L Street, NW, Suite 600, Washington, DC 20036, are incorporated ~~herein~~ by reference, and no further editions or amendments and are on file ~~in~~ with the ~~office of the Secretary of State~~ Board:

1. ANSI Z80.1-~~1987~~ 1999, "Prescription Ophthalmic Lenses-Recommendations." ~~and no further changes.~~
2. ANSI ~~Z80.2-1989~~ Z80-20-1998, "~~Rigid~~ Contact Lenses-~~Requirements~~ Standard Terminology, Tolerances, Measurements And Physiochemical Properties." ~~and no further changes.~~
3. ANSI Z80.5-~~1979~~2004, "Requirements for ~~Dress~~ Ophthalmic Frames."
4. ANSI Z87.1-~~1989~~2003, "~~Practice for~~ Occupational and Educational Personal Eye and Face Protection Devices." ~~and no further changes.~~
5. ANSI Z80.9-1998 "Optical Devices for Low Vision."

R4-20-120. Continuing Education; Hours Required; Reporting

A. Within every three-year period from the date of obtaining a license, ~~or renewing a license, subsequent to the effective date of this rule~~, a person licensed as a dispensing optician shall complete no fewer than 12 ~~twelve clock~~ hours of ~~approved~~ continuing education that is approved by the Board for credit.

B. Each licensee shall submit documentation to the Board verifying that the licensee has completed 12 ~~twelve clock~~ hours or more of continuing education, ~~as required,~~ within each three-year ~~subsequent~~ period. ~~Any false statement by a licensee in the documentation shall be grounds for disciplinary action, including suspension or revocation of license.~~ The licensee shall provide documentation ~~shall~~ that identify identifies the courses and the number of credit hours completed and ~~shall~~ include the following:

1. If the course is from a school approved by the Commission on Opticianry Accreditation or college-accredited course, proof of course completion and the number of credits earned.
2. If the course is part of an event, a certificate of completion issued by the sponsor which identifies each part completed.
3. If the course is a home-study course, a certificate of completion issued by the sponsor and the number of credits earned.
4. For any other course, a certificate of completion issued by the sponsor or presenter and the number of credits earned.
5. If the licensee cannot obtain the above documentation, any other documents, affidavits, or testimony which provides assurance that the licensee has completed the requirements.

C. Of the twelve ~~clock~~ hours of continuing education, each licensee shall ~~meet the following minimum course requirements as follows~~ obtain at least:

1. Four ~~clock~~ hours ~~of~~ in eyeglass fitting and dispensing;
2. Three ~~clock~~ hours ~~of~~ in contact lens fitting and dispensing;
3. One ~~clock~~ hour ~~of~~ in state ~~and~~ or national opticianry standards.

D. Hours will be measured as follows: ~~any single session covering not less than two hours and forty minutes will be assigned three hours; any single session covering not less than one hour and forty minutes will be assigned two hours; any single session covering not less than fifty minutes will be assigned one hour~~ one credit hour will be assigned for each 50 minutes of a single session.

E. The Board shall discipline any licensee who submits false information for continuing education documentation.

F. A licensee shall not apply any hours accrued during one reporting period to any subsequent reporting period.

R4-20-121. Continuing Education; Approval of Courses

A. ABO ~~American Board of Opticianry~~ and NCLE ~~National Contact Lens Examiners~~ courses ~~shall be~~ are approved by the Board for continuing education credit. Other individuals or organizations seeking ~~credit for or~~ approval of a continuing education course for credit shall apply to the Board 45 days ~~prior to~~ before the date the course is offered. The application shall contain the following information on the course:

1. Title and description of course content ~~for each course.~~;
2. Time, date, and place;
3. Number of credit hours;
4. Name of the sponsor and presenter; and
5. Brief curriculum vitae of the presenter.

B. ~~Any excessive hours accrued during one reporting period may not be applied to any subsequent reporting period.~~

R4-20-122. Agency Record; Directory of Substantive Policy Statements

The official rulemaking record for each rulemaking and a directory of substantive policy statements is located in the office of the Board and may be reviewed Monday through Friday, 8:00 a.m. to 5:00 p.m., except state holidays.

R4-20-123. Petition For Rulemaking; Review of Agency Practice or Substantive Policy Statements; Objection to Rule Based Upon Economic, Small Business, or Consumer Impact.

A person shall file a petition to adopt, amend, or repeal a rule or to review an existing agency practice or substantive policy statement that the petitioner alleges to constitute a rule under A.R.S. § 41-1033 or to object to a rule according to A.R.S. § 41-1056.01 as prescribed in this Section. Each petition shall contain:

1. The name and current address of the petitioner;
2. For the adoption of a new rule, the specific language of the proposed rule;

3. For the amendment of a current rule, the applicable A.A.C. citation and Section heading. The request shall include the specific language of the current rule, any language to be deleted shall be stricken through but legible, and any new language shall be underlined;
4. For the repeal of a current rule, the applicable A.A.C citation and Section heading;
5. The reasons the rule should be adopted, amended, or repealed, and if for an existing rule, why the rule is inadequate, unreasonable, unduly burdensome, or otherwise not acceptable. The petitioner may provide additional supporting information, including:
   a. Any statistical data or other justification, with clear reference to an attached exhibit;
   b. An identification of what persons or segment of the public would be affected and how they would be affected; and
   c. If the petitioner is a public agency, a summary of relevant issues raised in any public hearing, or as written comments offered by the public;
6. For a review of an existing Board practice or substantive policy statement alleged to constitute a rule, the reasons the existing Board practice or substantive policy statement constitutes a rule and the proposed action requested of the Board;
7. For an objection to a rule based upon the economic, small business or consumer impact, evidence that:
   a. The actual economic, small business, or consumer impact significantly exceeded the impact estimated in the economic, small business, and consumer impact statement submitted during the making of the rule; or
   b. The actual economic, small business, or consumer impact was not estimated in the economic, small business, and consumer impact statement submitted during the making of the rule and the actual impact imposes a significant burden on persons subject to the rule; and
8. The signature of the person submitting the petition.

R4-20-124. Public Comments

A. On or before the close of record, a person may comment upon a rule proposed by the Board by submitting written comments to the Board.

B. The Board considers a written comment submitted on the date it is received by the Board, except if a comment is mailed the date of receipt is the postmark date.

C. The Board shall consider all written comments submitted during the public comment period.

R4-10-125. Oral Proceedings

A. A person requesting an oral proceeding as prescribed in AR.S. § 41-1023, shall:
1. File a request with the Board;
2. Include the name and current address of the person making the request; and
3. Refer to the proposed rule and include, if known, the date and issue of the Arizona Administrative Register in which the proposed rule was published.

B. The Board shall record an oral proceeding either electronically or stenographically, and make any cassette tapes, transcripts, and written comments submitted during the proceeding part of the official record;

C. The presiding officer shall use the following guidelines to conduct an oral proceeding:
1. Registration of attendees. Registration of attendees is voluntary.
2. Registration of persons intending to speak. Registration information shall include the person's name, representative capacity, if applicable, a notation of the person's position with regard to the proposed rule and the approximate length of time the person wishes to speak.
3. Opening of the record. The presiding officer shall open the proceeding by identifying the rules to be considered, the location, date, time, and purpose of the proceeding, and present the agenda;
4. A statement by Board representative. A Board representative shall explain the background and general content of the proposed rules;
5. A public oral comment period. The presiding officer may limit comments to a reasonable time, as determined by the presiding officer and to prevent undue repetition; and
6. Closing remarks. The presiding officer shall announce the location where written public comments are to be sent.

R4-20-126. Written Criticism of Rule

A. Any person may file a written criticism of an existing rule with the Board.

B. The criticism shall clearly identify the rule and specify why the existing rule is inadequate, unduly burdensome, unreasonable, or otherwise improper.

C. The Board shall acknowledge receipt of a criticism within 15 days and shall place the criticism in the official record for review by the Board under A.R.S. § 41-1056.

Table 1. Time-frames (in days)

Type of Approval	Statutory Authority	Overall Time-frame	Administrative Completeness Time-frame	Substantive Review Time-frame
Approval to Take a Dispensing Optician Examination (R4-20-102)	A.R.S. § 32-1682	90	30	60
License by Examination (R4-20-102)	A.R.S. § 32-1682 A.R.S. § 32-1684	60	30	30
License by Comity (R4-20-107)	A.R.S. § 32-1683	90	30	60
Optical Establishment License R4-20-110	A.R.S. § 32-1684.01	30	10	20
Optician's License Renewal (R4-20-109)	A.R.S. § 32-1682	60	30	30
Establishment License Renewal (R4-20-115)	A.R.S. § 32-1684.01	60	30	30

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

[R05-345]

PREAMBLE

1. Sections Affected	Rulemaking Action
R20-6-1101	Repeal
R20-6-1101	New Section
R20-6-1102	Repeal
R20-6-1102.01	Repeal
R20-6-1103	Repeal
R20-6-1104	Repeal
R20-6-1105	Repeal
R20-6-1106	Repeal
R20-6-1107	Repeal
R20-6-1108	Repeal
R20-6-1109	Repeal
R20-6-1110	Repeal
R20-6-1111	Repeal
R20-6-1112	Repeal
R20-6-1113	Repeal
R20-6-1114	Repeal
R20-6-1115	Repeal
R20-6-1116	Repeal
R20-6-1117	Repeal
R20-6-1118	Repeal
R20-6-1119	Repeal
R20-6-1120	Repeal
R20-6-1121	Repeal
Appendix A	Repeal
Appendix B	Repeal
Appendix C	Repeal
Appendix D	Repeal
Appendix E	Repeal
Appendix F	Repeal

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 20-143 and 20-1133

Implementing statutes: A.R.S. §§ 20-142, 20-143, and 20-1133

3. The effective date of the rules:

November 12, 2005

4. A list of all previous notices appearing in the *Register* addressing the final rule:

Notice of Rulemaking Docket Opening: 11 A.A.R 2040, May 27, 2005

Notice of Proposed Rulemaking: 11 A.A.R. 2074, June 3, 2005

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name:	Margaret McClelland
Address:	Department of Insurance 2910 N. 44th St., Suite 210 Phoenix, AZ 85018
Telephone:	(602) 912-8456
Fax:	(602) 912-8452

6. An explanation of the rule, including the agency's reason for initiating the rule:

The National Association of Insurance Commissioners (NAIC) has adopted amendments to its Medicare Supplement Insurance Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (Model Regulation) to make the Model Regulation compliant with the Medicare Modernization Act (MMA), which was passed by the United States Congress in 2003. The amendments effectively do the following:

- Add two new plans to the existing standard Medigap plans. The two new plans known as Plan K and Plan L, are designed to reduce the over-utilization of "first-dollar" coverage features of other Medigap plans, thus providing a financial incentive to beneficiaries to help control costs. Both new plans are similar, but differ in the percentage of coverage for claims and in maximum annual out-of-pocket limit amounts.
- Revise standard H, I, and J plans to eliminate prescription drug coverage for those who enroll in Medicare Part D.
- Prohibit the sale of prescription drug coverage in Medigap after December 30, 2005 (when Part D comes into effect).

This rulemaking is necessary to conform Arizona's Medicare supplement insurance rules with the recently adopted federal regulations pertaining to Medicare supplement insurance and the recently adopted NAIC Model Regulation.

This rulemaking incorporates by reference the Model Regulation with some modifications that are necessary to address Arizona standards. The overall purpose of this rulemaking is to benefit consumers by providing for the standardization of coverage and simplification of terms and benefits of Medicare supplement policies, as well as to facilitate public understanding and comparison of the policies. This rulemaking will also provide uniformity with other states that will also adopt this Model Regulation making compliance easier for insurers who will not have to meet different requirements for each state.

The Department requests that this rulemaking become effective upon filing with the Office of the Secretary of State under A.R.S. § 41-1032(2) and (3) in September 2005. The September 2005 effective date will allow the Department to review and approve filings for the sale of new plans K and L prior to the January 1, 2006, effective date of the standardized federal Medicare requirements. This will allow insurers avoiding a lengthy wait for insurers to be able to offer, sell and issue their products until well after January 1, 2006 if the Department is not able to begin reviewing and approving their filings prior to January 1, 2006.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

None

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

The consumers who will be impacted are consumers of Medicare supplement insurance who will benefit from uniformity and simplification of terms and benefits of Medicare supplement policies, as well as a better ability to compare and understand such policies.

The Department is not aware of small businesses that will be directly impacted by this rule.

There will be a minimal economic impact on the Department for costs associated with the rulemaking process.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

R20-6-1101 is revised to divide the rule into subsections (A), (B), and (C). A new subsection (C) is added regarding the applicability R20-6-1101.

The proposed subsections (A)(7) and (A)(8) are deleted in response to comments, allowing Model Regulation language to remain unchanged.

New subsections (7), (8), and (9) are added to correct typographical errors in the Model Regulation.

Other changes are made to make the rule more clear, concise and understandable and to correct typographical errors.

11. A summary of the comments made regarding the rule and the agency response to them:

(BCBSAZ)

1. Comment: The Department received several comments objecting to the Department's selection of Option 1, the prohibition of attained-age rating in R20-6-1101(A)(6).

Response: Joining the majority of the other states in adopting the Model Regulations, Arizona selected Option 1 of Section 15F of the Model Regulation (Option 1). Option 1 prohibits attained-age rating in determining rates for Medicare Supplement insurance policies. Arizona joins at least 12 other states in adopting this option for the purpose of protecting a very vulnerable segment of our population, Arizona senior citizens. The Director has determined that protection of this class of citizens is a benefit to Arizona and all of its citizens. The selection of Option 1 will not only benefit the families of those senior consumers, but it will also benefit governmental agencies and taxpayers who might otherwise be economically burdened to provide benefits for these senior consumers who cannot maintain their Medicare Supplement insurance or Medigap.

One commenter on this rulemaking is the nation's largest marketer of Medicare supplement insurance, providing Medicare supplement insurance to 2.5 million AARP members nationwide. That carrier is also the largest provider of Medicare supplement insurance in Arizona. This insurer covers approximately 61,000 Arizona AARP members under Medigap using community rating. The next largest Medigap carrier provides Medicare supplement insurance to approximately 13,000 Arizona seniors. In fact, the AARP web site states, "No Age Rating – All plans are community rated. The cost does not automatically go up just because you get older." This is a clear indicator to the Director that purchasing Medigap coverage, without significant rate increases as one grows older, is a matter of importance to seniors.

Arizona is not alone in its recognition of the need to protect this particular class of consumers. At least 12 other states currently prohibit attained-age rating on Medigap policies. Florida, like Arizona, attracts large numbers of senior retirees, a comparatively large number of potential purchasers of Medicare supplement insurance. Notably, Florida law prohibits the use of attained-age rating in the sale of Medicare supplement insurance. Florida did not experience a significant exodus of insurers unwilling or unable to provide Medicare supplement insurance to its senior consumers under other available rating methodologies. Indeed, some insurers expressing concern about prohibition of attained-age rating in Arizona competitively offer their products in Florida and other states using either issue age or community rating methodologies and the Department believes that these and other insurers will likewise be able to competitively offer their products in Arizona.

Arizona has a large senior citizen population. According to recent U. S. Census data, the senior population in Arizona grew 32.4% between 1993 and 2003, making Arizona third in the United States in the percentage of increase of senior citizen population. All indications are that Arizona will continue to lead the nation in senior citizen population growth and, for this reason, the Director has determined that there is a need for protecting the affordability of Medicare supplement insurance in Arizona.
Under attained-age rating, a consumer purchases insurance at a rate that consistently increases as the consumer's age increases, resulting in significantly higher rates when the insured reaches 70+ years. Under the issue age rating and community rating methodologies, as Option 1 would allow, a consumer purchases insurance at a rate that

remains level throughout the term of the policy. While this distinction might be in writing in their policy, it is often difficult for senior consumers to comprehend the intricacies of the document. Insurance is a complex product and is often difficult for any consumer, particularly seniors, to understand.

By selection of Option 1, the Department is attempting to secure the affordability of Medigap insurance for Arizona's seniors, while still allowing insurers the ability to fairly price and rate Medicare supplement insurance policies. Under the attained-age rating methodology, these senior policy holders may find that their premiums are increasing at a rate they can no longer afford, at the time they need coverage the most. Typically, this is a time when a senior policy holder's financial resources and ability to generate new income are lowest. After years of premium payments, if the Medicare supplement insurance policy lapses, senior consumers might find that they are unable to provide for their medical needs and become a burden on their families or on governmental agencies, or will simply have to do without medical care. For all the foregoing reasons, the Department selected Option 1 as most appropriate for Arizona consumers.

2. Comment: Prohibition of attained-age rating would imply the need for the build-up of substantial statutory contract reserves in early policy years potentially creating a surplus strain associated with new business making the Medicare supplement market less attractive in those jurisdictions resulting in fewer carriers.

   Response: The Department disagrees with this comment and has no evidence that this would be the case. In Florida where attained-age rating is prohibited, the need for contract reserves has had no impact on the willingness of carriers to write Medicare supplement business. This commenter actively writes Medicare business in Florida, as does the largest provider of Medicare supplement insurance. The Department believes that will also be the case for carriers in Arizona.

3. Comment: A commenter expressed concern that switching to this rating methodology will cause disruption to some carriers and would require them to retain outside consultants to assist in establishing rates and setting of active life reserves resulting in an increase in administrative costs.

   Response: It is the Department's experience based on company rate filings with the Department that, generally, insurers have actuaries on staff or existing arrangements with outside consultants that assist the company in establishing rates and setting of active life reserves. There will be some actuarial costs involved in developing new issue age rates for those now using attained-age rates. Some companies using attained-age rating in Arizona are already using issue age rating in other states and those companies will be able the use existing databases and worksheets, causing savings of time and expense. Federal law already mandates that insurers file their rates annually with the Department and most insurers revise their rates as part of the required annual filing. Consequently, rate changing is a usual and ongoing process for those companies. Therefore, the Director believes that any costs as a result of this rule will be minimal.

4. Comment: The Department received comments that expressed concern that the requirement could impact its ability to continue offering its Medicare supplement products at low and competitive cost to consumers potentially reducing the number of consumers willing to purchase Medicare supplement products

   Response: The commenters provided no further information and the Department has no information to indicate that this would in fact be the case. Based on the experience of other states that prohibit attained-aged rating, insurance carriers do in fact continue to offer Medicare supplement products in those states at competitive costs to consumers. The Department compared the premium rates at age 65 of two of Arizona's largest Medicare supplement insurance carriers. One carrier uses attained-age rating and the other uses issue age rating. For age 65, the carrier that uses issue-age rating offers its product at a lower rate than does the carrier that uses attained-age rating. This is clear evidence that use of the issue-age rating methodology does not mean that products cannot be issued at competitive costs to consumers. The Department has no information that indicates that consumers will not continue to purchase Medicare supplement products that are competitively priced.

5. Comment: Prohibition of attained-age rating will require higher rates at issue to fund increasing morbidity with increasing attained age, potentially reducing the number of consumers willing to purchase Medicare supplement products. Prohibition of an attained-age rating as an important morbidity determinant will increase the variability in financial results under such products having the following result:
   a. Some carriers will increase rates, as more substantial contingency loads become necessary in order to maintain a reasonable probability of realizing targeted profit margins.
   b. Some carriers will assess the additional risk as unacceptable and decide to exit the market, reducing the number of alternatives to consumers.

   Response: As age advances, the morbidity assumptions are actuarially the equivalent for both attained-age and issue-age rating. The carriers should find no material differences in contingency loads or risks. The Department knows of no evidence that there would be a reduction in the number of consumers willing to purchase Medicare supplement products. In Florida where attained-age rating has been prohibited since 1993, there has been no evidence of a reduction in the number of consumers willing to purchase the products.

6. Comment: The drafting note to 15(G) of the NAIC Model Regulation suggests that states should assess their Medicare supplement marketplace to determine whether a regulatory response to attained rating is desirable.

   Response: The Director has assessed Arizona's Medicare supplement market place. Arizona has a large senior citizen population. According to recent U. S. Census data, the senior population in Arizona grew 32.4% between 1993 and 2003, making Arizona third in the United States in the percentage of increase of senior citizen population. All indications are that Arizona will continue to lead the nation in senior citizen population growth and, for this reason, the Director has determined that there is a need for protecting the affordability of Medicare supplement insurance in Arizona so that when a senior citizen becomes older, infirmed and less able to afford significantly higher premiums, that insurance will not then be priced outside of the insured's reach as a result of attained-age rating.

   The Department receives numerous telephone calls and inquiries from Arizona senior citizens who are confused about their Medicare supplement policies and who have found their policies to have become more expensive than they can afford, and they have no clear understanding of what has happened. Many then have to allow their policies to lapse leaving them without coverage for essential medical care when they need it. The Department believes this necessary regulatory response will help to lessen this negative impact on these seniors.

7. Comment: There is a well-established correlation between attained-age and morbidity for many types of insurance products, including Medicare supplement. Thus attained-age represents one of the most important and commonly utilized factors within the rating of such products. Validity of attained-age rating for Medicare supplement products is recognized and accepted by a large majority of state statutes.

   Response: While attained-age rating has been used in Arizona, it is not currently recognized by listing in statute or rule in Arizona. The Department is not aware of what other states, if any, recognize attained-age rating in state statutes. The Department is aware that some states do prohibit attained-age rating. In Arizona, the Director has determined that because of the Medicare supplement marketplace and particular circumstance in Arizona regarding its large senior population, prohibition of attained-age rating is an appropriate consumer protection regulatory response.

8. Comment: With issue-age rating, would carriers be required to maintain nonforfeiture values to refund premiums, if for example, a customer cancels a policy?

   Response: No.

9. Comment: The prohibition of attained-age rating appears to exceed the rulemaking purposes of benefiting consumers of Medicare supplement policies and facilitating public understanding and comparison of policies and uniformity with other states.

   Response: The Department believes that this rulemaking will achieve its purposes of benefiting consumers of Medicare supplement policies, facilitating public understanding and comparison of policies, and uniformity with other states. The consumers the Department seeks to benefit are senior citizens who are consumers of Medicare supplement insurance policies. These senior citizens often purchase these policies when they are younger intending to maintain this coverage throughout their remaining years as they become older, infirmed, and likely less

able financially to afford to maintain a considerably more expensive policy. Often the seniors are forced to cancel or allow the policy to lapse forfeiting benefits under the policy, after years of payment of the policy, due to considerable increases in the cost of the premiums at the time when they are most likely to need it.

By incorporating the Model Regulation by reference, the Department facilitates consistency in requirements and provisions in policies and uniformity with other states, for the benefit of consumers and industry.

10. Comment: The attained-age methodology provides choice and affordability for young consumers. Prohibition of attained-age rating reduces consumer choice, since it eliminates a pricing approach commonly used by carriers.

    Response: In the case of both attained-age and issue-age rating, youth dictates affordability of initial premiums. The younger the age at the time of purchase, the more affordable the policy will be at that time. If a "young" consumer purchases this insurance under issue-age rating, the cost of premiums will be at that company's lower rate and will remain at that lower rate throughout the term of the policy. Under attained-age rating, that same "young" consumer would purchase at that company's lower rate at the time of purchase, but over the term of the policy, as that consumer ages, the consumer will face consistent and significant increases in the cost of the premiums. So, over the term of the attained-age rate policy, if the "young" consumer holds the policy until age 70 and above, that consumer could pay significantly more for that coverage. While the attained-age methodology might provide some choice to a young consumer, it is not likely to provide affordability in the consumer's older years when that consumer is most likely to need it.

11. Comment: Commenter requests that the Department not include either of the attained-age rating options in Section 15(G) of the NAIC Model Regulation.

    Response: Currently the Department does not have a reference in its rules to a required rating methodology. However, the Director has determined that a regulatory response is necessary in Arizona to address the numerous complaints and concerns expressed to the Department about premium increases that make the insurance unaffordable at the time when senior citizens need it most. The Model Regulation suggests 2 options for rating methodology. The Director has determined that to meet the needs of Arizona consumers, Option 1 provides the best consumer protection.

12. Comment: A commenter requests that the Department adopt option 2 from Section G, subsection 15 F.

    Response: Option 2 is an option for attained-age rating. The Department has determined that Option 1 best protects Arizona consumers.

13. Comment: A commenter suggests that 36 of 49 Arizona Medigap insurers to some extent use attained-age rating, and requests that the Department retain the current options available in Arizona to purchase a policy that uses attained-age, issue-age, or community rating methodologies.

    Response: The Department cannot verify the conclusions drawn by the commenter for the numbers cited by the commenter, but for reasons previously discussed, the Department chooses Option 1 of the Model Regulation that will prohibit attained-age rating. Other rating methodology options will remain available.

14. Comment: A commenter objects to modifications to subsections R20-6-1101(7) and (8) that modify Sections 23A and 23B of the Model Regulation respectively by deleting the phrase "for similar benefits." The commenter questions why this language was removed and expressed concern that this variation from the Model Regulation could lead to adverse selection by a policyholder for benefits not previously covered under the policy being replaced.

    Response: In response to this comment, the Department will restore the phrase "for similar benefits" by deleting the proposed subsections (A)(7) and (A)(8) from R20-6-1101.

15. Comment: A commenter requests that in light of the effective date of January 1, 2006, in the Model Regulation, the Department should add language to the rule that states, "insurers are permitted to continue to use currently approved forms as appropriate through December 31, 2005. Insurers may offer any authorized plan upon approval of the Director."

    Response: The Department will add language to the rule that states, "This Section is applicable to policies issued on or after January 1, 2006." This will permit insurers to continue to offer previously authorized plans, but allows the Department to begin in September 2005 to review plans and documents that will be issued in January. This benefits the insurer because the insurer would not otherwise be able to submit policies for approval in advance for January 2006 effective date.

16. Comment: The Department should not seek an immediate effective date for the rules, but allow the rules to become effective on January 1, 2006 as in the Model Regulation.

    Response: The Department intends to seek immediate effectiveness of the rule in September 2005. This will comply with the federal regulation and permit insurers to continue to offer previously authorized plans, but allows the Department to begin in September 2005 to review plans and documents that will be issued in January. This benefits the insurer because the insurer would not otherwise be able to submit policies for approval in advance for January 2006 effective date.

17. Comment: One additional suggestion we are making in the nature of a technical correction is to add an effective date section providing for the fact that, while some changes to forms should not be required until the Medicare Part D program begins in 2006 (e.g., deletion of outpatient prescription drug benefits from the cover pages and Outlines of Coverage for Plans H-J), there is no reason why other changes cannot be implemented in 2005, such as approval to offer Plans K and L once the regulation has authorized them. (CMS has taken the position that Plans K and L may be sold in 2005 once a state has adopted the new regulation.) In order to standardize and therefore simplify nationwide implementation of the new regulation, we are suggesting that all states add a provision regarding effective date along the following lines:

    > "This regulation is effective on [effective date]. Insurers are permitted to continue using current forms, or to make changes to current forms if offering Plan K or L, as appropriate through 2005. Insurers may offer any authorized plan upon approval by the [Commissioner of Insurance or other authority]."

    Response: The Department will add language to the rule that states, "This Section is applicable to policies issued on or after January 1, 2006." This will permit insurers to continue to offer previously authorized plans, but allows the Department to begin in September 2005 to review plans and documents that will be issued in January 2006. This benefits the insurer because the insurer would not otherwise be able to submit policies for approval in advance of the January 2006 effective date.

18. Comment: There is redundant language in Section 8A(7)(b) of the NAIC Model. The redundant language is shown lined out: "If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted ~~(~~effective as of the date of termination of entitlement~~) as of the termination of entitlement~~ if the policyholder or certificateholder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period~~, effective as of the date of termination of entitlement~~."

    Response: This substantive language was developed through a joint effort of the NAIC, the Centers for Medicare and Medicaid Services (CMS), industry representatives and other interested parties after extensive review, comment, and consideration of the requirements of the federal Medicare Supplement Act. The Department will not change this language as it could change the substantive meaning intended by the framers of the language.

19. Comment: The heading for the Medicare Part B table in the Plan E Outline of Coverage should refer to "Medical Services – Per Calendar Year" rather than "Medical Services – Per Benefit Period."

    Response: This is a typographical error made to the Model Regulation. The Department will revise the rule to correct it accordingly.

20. Comment: In the Outlines of Coverage for Plan F/High Deductible Plan F and Plan J/High Deductible Plan J, the "Plan Pays" and "You Pay" column headings in some of the tables lack proper bracketing. All of these column headings should be bracketed as follows: "[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS" and "[IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY."

    Response: This is a typographical error made to the Model Regulation. The Department will revise the rule to correct it accordingly.

21. Comment: In the Plan J/High Deductible Plan J Outline, reference to the outpatient prescription drug deductible should be removed from the last sentence of the bold, bracketed paragraph above the Part A and Part B tables: "This includes the Medicare deductibles for Part A and Part B, but does not include ~~the plan's separate outpatient prescription drug deductible or~~ the plan's separate foreign travel emergency deductible."

    Response: This is a typographical error made to the Model Regulation. The Department will revise the rule to correct it accordingly.

22. Comment: In the Plan J/High Deductible Plan J Outline, hospice care should appear at the end of the Part A table rather than the top of the Part B table.

    Response: This is a typographical error made to the Model Regulation. The Department will revise the rule to correct it accordingly.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

13. Incorporations by reference and their location in the rules:

In R20-6-1101, Department incorporates by reference the Model Regulation to Implement the National Association of Insurance Commissioners Medicare Supplement Insurance Minimum Standards Model Act, October 2004 (Model Regulation), and no future editions or amendments, which is on file with the Office of the Secretary of State and available from the Department of Insurance, 2910 N. 44th St., Phoenix, AZ 85018 and the National Association of Insurance Commissioners, Publications Department, 2301 McGee St., Suite 800, Kansas City, MO 64108. The Model Regulation is modified as set forth in R20-6-1101

14. Was this rule previously made as an emergency rule?

No.

15. The full text of the rules follows:

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

Section

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

R20-6-1101. ~~Applicability and Scope~~ Repealed

~~**A.** Except as otherwise specifically provided in R20-6-1104, R20-6-1109, R20-6-1110, R20-6-1113 and R20-6-1118, this Article applies to:~~

~~1. All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this Article; and~~

~~2. All certificates issued under group Medicare supplement policies and delivered or issued for delivery in this state.~~

~~**B.** This Article does not apply to a policy or contract of:~~

~~1. One or more employers or labor organizations; or~~

~~2. The trustees of a fund established by one or more employers or labor organizations or combination of employers and labor organizations, for their employees, former employees, or a combination of employees and former employees, or for members, former members, or a combination of members and former members of the labor organizations.~~

R20-6-1101. Incorporation by Reference and Modifications; Applicability

A. The Department incorporates by reference the Model Regulation to Implement the National Association of Insurance Commissioners (NAIC) Medicare Supplement Insurance Minimum Standards Model Act, October 2004 (Model Regulation), and no future editions or amendments, which is on file with the Department of Insurance, 2910 N. 44th St., Phoenix,

AZ 85018 and available from the National Association of Insurance Commissioners, Publications Department, 2301 McGee St., Suite 800, Kansas City, MO 64108.

B. The Model Regulation is modified as follows:

1. In addition to the terms defined in the Model Regulation, the following definitions apply:
   a. "Agent" means an insurance producer as defined in A.R.S. § 20-281(5).
   b. "Commissioner" means the Director of the Arizona Department of Insurance.
   c. "HMO" and "health maintenance organization" mean a health care services organization as defined in A.R.S. § 20-1051(7).
   d. "Regulation" means Article.
2. Section 8A(7)(c) reads:
   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) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss of the group health plan and pays the premium attributable to the supplemental policy period, effective as of the date of termination of enrollment in the group health plan.
3. A new subsection G is added to Section 15 as follows:
   G. An insurer shall not file or request approval of a rate structure for its Medicare supplement policies or certificates based upon attained-age rating as a structure or methodology after September 13, 2005.
4. The heading for the table for "**PLAN E, MEDICARE (PART B)-MEDICAL SERVICES-PER BENEFIT PERIOD**" is revised to "**PLAN E, MEDICARE (PART B)–MEDICAL SERVICES-PER CALENDAR YEAR**."
5. Tables for **PLAN F or HIGH DEDUCTIBLE PLAN F** are revised as follows:
   a. For the table entitled "**PARTS A & B**" a column heading is revised from "**AFTER YOU PAY $[1690] DEDUCTIBLE,** PLAN PAYS**" to "**[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS**."
   b. For the table entitled "**PARTS A & B**" a column heading is revised from "**IN ADDITION TO $[1690] DEDUCTIBLE,** YOU PAY**" to **["IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY**."
   c. For the table entitled "**OTHER BENEFITS – NOT COVERED BY MEDICARE**" a column heading is revised from "**AFTER YOU PAY $[1690] DEDUCTIBLE,** PLAN PAYS**" to "**[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS**."
   d. For the table entitled "**OTHER BENEFITS – NOT COVERED BY MEDICARE**" a column heading is revised from "**IN ADDITION TO $[1690] DEDUCTIBLE,** YOU PAY**" to **["IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY,**"
6. Tables for **PLAN J** or **HIGH DEDUCTIBLE PLAN J** are revised as follows:
   a. For the tables entitled "**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**" and "**MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR**," the last sentence of the second paragraph under the title is revised to: "**This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible**."
   b. For the table entitled "**MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR**," all information for "**HOSPICE CARE**" is moved to the bottom of the table for "**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**."
   c. For the table entitled "**PARTS A & B**" a column heading is revised from "**AFTER YOU PAY $[1690] DEDUCTIBLE,** PLAN PAYS**" to "**[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS**."
   d. For the table entitled "**PARTS A & B**" a column heading is revised from "**IN ADDITION TO $[1690] DEDUCTIBLE,** YOU PAY**" to **["IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY**."
   e. For the table entitled "**PARTS A & B OTHER BENEFITS – NOT COVERED BY MEDICARE**" a column heading is revised from "AFTER YOU PAY $[1690] DEDUCTIBLE,** PLAN PAYS" to "**[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS**."
   f. For the table entitled "**PARTS A & B OTHER BENEFITS – NOT COVERED BY MEDICARE**" a column heading is revised from "**IN ADDITION TO $[1690] DEDUCTIBLE,** YOU PAY**" to **["IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY**."

C. This Section is applicable to Medicare supplement insurance policies issued on or after January 1, 2006.

R20-6-1102. ~~Definitions~~ Repealed

~~In this Article, the definitions in A.R.S. §§ 20-102 through 20-105 and the following definitions apply:~~

1. ~~"Activities of daily living" means, but is not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.~~
2. ~~"Applicant" means:~~
   a. ~~In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits;~~

and

b. In the case of a group Medicare supplement policy, the proposed certificate holder.

3. "At home recovery visit" means the period of time required to provide at home recovery care, without limit on the duration of time, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.
4. "Bankruptcy" means that a Medicare+Choice organization which is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in Arizona.
5. "[ ]" means the amount or text within the brackets is subject to change or variation.
6. "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.
7. "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.
8. "Certificate form" means the form on which a certificate is delivered or issued for delivery by an issuer.
9. "Compensation" means pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of a policy or certificate including but not limited to bonuses, gifts, prizes, awards, and finders' fees.
10. "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.
11. "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 63 days.
12. "Creditable coverage" means the type of insurance coverage described in R20-6-1102.01.
13. "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in 29 U.S.C. § 1002 (Employee Retirement Income Security Act).
14. "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services of a Medicare Select issuer or its network providers.
15. "Home" means any place used by an insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility is not considered the insured's place of residence.
16. "Insolvency" means that an issuer, licensed to transact the business of insurance in Arizona, 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.
17. "Issuer" means insurance companies, fraternal benefit societies, health care services organizations, hospital and medical service associations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.
18. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.
19. "Medicare+Choice plan" means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. § 1395w-28(b)(1), and includes:
    a. Coordinated care plans that provide health care services, including, but not limited to, health care services organization plans (with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans;
    b. Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and
    c. Medicare+Choice private fee-for-service plans.
20. "Medicare Handbook" means the publication distributed by the United States Department of Health and Human Services, Health Care Financing Administration, describing Medicare benefits available and premium, deductible, and coinsurance amounts payable.
21. "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.
22. "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.
23. "Medicare supplement policy" means a group or individual policy of disability insurance or a subscriber or member contract of hospital and medical service associations or health care services organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. §§ 1395 et seq.) or a policy issued under a demonstration project specified in 42 U.S.C. § 1395ss Subsection (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.
24. "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with an issuer to provide benefits insured under a Medicare Select policy.
25. "Policy form" means a form on which a policy is delivered or issued for delivery by an issuer.

~~26. "Restricted network provisions" means any provision that conditions the payment of benefits, in whole or in part, on the use of network providers.~~
~~27. "Secretary" means the Secretary of the United States Department of Health and Human Services.~~
~~28. "Service area" means the geographic area within which an issuer is authorized to offer a Medicare Select policy.~~

R20-6-1102.01.~~Creditable Coverage~~ Repealed

~~**A.** Creditable coverage means, with respect to an individual, coverage provided under:~~
~~1. A group health plan;~~
~~2. Any health insurance plan;~~
~~3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);~~
~~4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under 42 U.S.C. § 1928;~~
~~5. Chapter 55 of Title 10 United States Code (CHAMPUS);~~
~~6. A medical care program of the Indian Health Service or of a tribal organization;~~
~~7. A state health benefits risk pool;~~
~~8. A health care plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);~~
~~9. A public health plan as defined in federal regulation; or~~
~~10. A health benefit plan under Section 5(e) of the Peace Corps Act [22 U.S.C. § 2504(e)].~~
~~**B.** Creditable coverage does not include:~~
~~1. Coverage only for accident or disability income insurance, or any combination of accident or disability income insurance;~~
~~2. Coverage issued as a supplement to liability insurance;~~
~~3. Liability insurance, including general liability insurance and automobile liability insurance;~~
~~4. Workers' compensation or similar insurance;~~
~~5. Automobile medical payment insurance;~~
~~6. Credit-only insurance;~~
~~7. Coverage for onsite medical clinics; or~~
~~8. Other similar insurance coverage, specified in federal regulations under which benefits for medical care are secondary or incidental to other insurance benefits.~~
~~**C.** Creditable coverage does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a plan:~~
~~1. Limited scope dental or vision benefits;~~
~~2. Benefits for long-term care, nursing home care, home health care, community based care, or any combination of these; and~~
~~3 Other similar, limited benefits as are specified in federal regulations.~~
~~**D.** Creditable coverage does not include the following benefits if offered as independent, non-coordinated benefits:~~
~~1. Coverage only for a specified disease or illness insurance, and~~
~~2. Hospital indemnity or other fixed indemnity insurance.~~
~~**E.** Creditable coverage does not include the following if it is offered as a separate policy, certificate, or contract of insurance:~~
~~1. Medicare supplemental health insurance as defined in 42 U.S.C. § 1882(g)(1) of the Social Security Act;~~
~~2. Coverage supplemental to the coverage provided in chapter 55 of Title 10, United States Code (CHAMPUS); and~~
~~3. Similar supplemental coverage provided to supplement coverage under a group health plan.~~

R20-6-1103. ~~Policy Definitions and Terms; Policy Provisions~~ Repealed

~~**A.** A person shall not advertise, solicit, or issue for delivery in this state a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms that conform to the requirements of this subsection:~~
~~1. "Accident," "accidental injury," "accidental means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external," "violent," "visible wounds" or similar words of description or characterization.~~
~~a. The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of diseases or bodily infirmity or any other cause, and occurs while the insurance coverage is in force."~~
~~b. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or any motor vehicle no-fault plan, unless prohibited by law.~~
~~2. "Benefit period" or "Medicare benefit period" shall be defined as starting the first day the insured enters the hospital and ends when the insured has been out of the hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row, including the day of discharge.~~
~~3. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined to exclude a~~

~~facility which is eligible for reimbursement as a convalescent nursing home, extended care facility or skilled nursing facility under Medicare.~~

4. ~~"Health care expenses" means expenses of health care services organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. Such expenses shall not include:~~
   a. ~~Home office and overhead costs,~~
   b. ~~Advertising costs,~~
   c. ~~Commissions and other acquisition costs,~~
   d. ~~Taxes,~~
   e ~~Capital costs,~~
   f. ~~Administrative costs, and~~
   g. ~~Claims processing costs.~~
5. ~~"Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals but shall not be defined to exclude any entity which is eligible for reimbursement as a "hospital" under Medicare.~~
6. ~~"Medicare" shall be defined in the policy and certificate. Medicare shall be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act as then constituted and any later amendments or substitutes thereof," or words of similar import.~~
7. ~~"Medicare eligible expenses" shall be defined as expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.~~
8. ~~"Physician" shall not be defined to exclude a provider which is eligible for reimbursement as a "physician" under Medicare.~~
9. ~~"Sickness" shall not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sickness or disease for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.~~

~~B.~~ ~~Except for permitted preexisting condition clauses as described in R20-6-1104(B)(1) and R20-6-1105(B)(1) of this Article, a person shall not advertise, solicit, or issue for delivery in this state a Medicare supplement policy or certificate with limitations or exclusions on coverage that are more restrictive than those of Medicare.~~

~~C.~~ ~~An issuer of a Medicare supplement policy or certificate shall not use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.~~

~~D.~~ ~~An issuer of a Medicare supplement policy or certificate in force in this state shall ensure that it does not contain benefits that duplicate benefits provided by Medicare.~~

R20-6-1104. ~~Minimum Benefit Standards for Policies or Certificates Issued for Delivery Before April 1, 1992~~ Repealed

~~A.~~ ~~A person shall not advertise, solicit, or issue a policy or certificate for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the minimum standards listed in this Section. These minimum standards do not preclude the inclusion of other provisions or benefits that are not inconsistent with these standards.~~

~~B.~~ ~~The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Article.~~

1. ~~A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months after the effective date of coverage because the losses arise from a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six 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 amount and copayment percentage factors. Premiums may be modified to correspond with these changes.~~
4. ~~A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:~~
   a. ~~Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or~~
   b. ~~Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.~~
5. ~~An issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation without prior written authorization from the director. The director may authorize cancellation or nonrenewal for reasons other than nonpayment of premium or material misrep-~~

~~resentation if the director finds that the renewal or continuation of the Medicare supplement policy or certificate would be hazardous or prejudicial to the issuer's certificate holders or policyholders.~~

~~6. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subsection (B)(8), the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:~~
   ~~a. An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and~~
   ~~b. An individual Medicare supplement policy that provides only the benefits required to meet the minimum standards described in R20-6-1105(C).~~

~~7. If membership in a group is terminated, the issuer shall:~~
   ~~a. Offer the certificate holder the conversion opportunities described in subsection (B)(6), or~~
   ~~b. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.~~

~~8. 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 replacement group policy shall not exclude preexisting conditions that would have been covered under the group policy being replaced.~~

~~9. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.~~

~~C. Minimum benefit standards.~~

~~1. Coverage of Part A Medicare-eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;~~

~~2. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;~~

~~3. Coverage of Part A Medicare-eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;~~

~~4. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;~~

~~5. Coverage under Medicare Part A for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells unless replaced or already paid for under Part B;~~

~~6 Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$100]; and~~

~~7. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, unless replaced or already paid for under Part A, subject to the Medicare deductible amount.~~

R20-6-1105. ~~Benefit Standards for Policies or Certificates Issued or Delivered on or After April 1, 1992~~ Repealed

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

~~B. General standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Article.~~

~~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 the losses arise from 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 different from 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 amount and copayment percentage factors. Premiums may be modified to correspond with these 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 and the issuer:~~

a. Shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and
b. Shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

6. If a Medicare supplement policy is terminated by a group policyholder and is not replaced as provided under subsection (B)(8), the issuer shall offer a certificate holder an individual Medicare supplement policy which, at the option of the certificate holder,
   a. Provides for continuation of the benefits contained in the group policy, or
   b. Provides for benefits that otherwise meet the requirements of subsection (B).
7. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:
   a. Offer the certificate holder the conversion opportunity described in subsection (B)(6); or
   b. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.
8. 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 replaced group policy on its date of termination. Coverage under the replacement group policy shall not exclude preexisting conditions that would have been covered under the group policy being replaced.
9. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned 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.
10. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period, not to exceed 24 months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to the medical assistance.
   a. If benefits and premiums are suspended under subsection (B)(10), and if the policyholder or certificate holder 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 the entitlement, if the policyholder or certificate holder provides notice of loss of the entitlement within 90 days after the date of the loss of the entitlement and pays the premium attributable to the period beginning when the entitlement to the medical assistance ended.
   b. A Medicare supplement policy shall provide that benefits and premiums under the policy are 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) of the Social Security Act. If the policy is suspended and if 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, if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.
   c. Reinstitution of coverage under subsection (B)(10)(a) or (B)(10)(b):
      i. Shall not provide for any waiting period with respect to treatment of preexisting conditions,
      ii. Shall provide for coverage that is substantially equivalent to coverage in effect before the date of the suspension, and
      iii. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

C. Standards for basic "core" benefits common to all benefit plans. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not instead of the basic "core" package. The "core" package consists of:

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
2. Coverage of Part A Medicare-eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
3. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A-eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, unless replaced; and

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.

D. Standards for additional benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by R20-6-1106:

1. Medicare Part A deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period;
2. 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;
3. Medicare Part B deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;
4. Eighty percent of the Medicare Part B excess charges: Coverage for 80% of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;
5. One hundred percent of the Medicare Part B excess charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;
6. Basic outpatient prescription drug benefit: Coverage for 50% of outpatient prescription drug charges, after a $250 calendar-year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare;
7. Extended outpatient prescription drug benefit: Coverage for 50% of outpatient prescription drug charges, after a $250 calendar-year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare;
8. Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, that would have been covered by Medicare if provided in the United States and that began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset;
9. Preventive medical care benefit: Coverage for the following preventive health services:
   a. An annual clinical preventive medical history and physical examination that may include tests and services described in subsection (D)(9)(b) and patient education to address preventive health care measures;
   b. Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:
      i. Digital rectal examination;
      ii. Dipstick urinalysis for hematuria, bacteriuria and proteinuria;
      iii. Pure tone, air only, hearing screening test, administered or ordered by a physician;
      iv. Serum cholesterol screening every five years;
      v. Thyroid function test; and
      vi. Diabetes screening;
   c. Tetanus and diphtheria booster every 10 years;
   d. Any other tests or preventive measures determined appropriate by the attending physician; and
   e. Reimbursement shall be for the actual charges up to 100% of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare;
10. At-home recovery benefit: Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery;
    a. Coverage requirements:
       i. At-home recovery services provided must be primarily services that assist in activities of daily living; and
       ii. The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment is approved by Medicare;
    b. Coverage is limited to:
       i. No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment,
       ii. The actual charges for each visit to a maximum reimbursement of $40 per visit,
       iii. Sixteen thousand dollars per calendar year,

~~iv. Seven visits in any one week,~~
~~v. Care furnished on a visiting basis in the insured's home,~~
~~vi. Services provided by a care provider as defined in R20-6-1102 (4),~~
~~vii. At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded, and~~
~~viii. At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit.~~

~~c. Coverage is excluded for:~~
~~i. Home care visits paid for by Medicare or other government programs; and~~
~~ii. Care provided by family members, unpaid volunteers, or providers who are not care providers; and~~

~~11. New benefits: An issuer may, with the prior approval of the Director, offer policies or certificates with new or innovative benefits that do not violate any provision of A.R.S. Title 20, or otherwise conflict with this Article and are in addition to the benefits provided in a policy or certificate that otherwise comply with the applicable standards. The new benefits may include benefits that are appropriate to Medicare supplement insurance, new, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies.~~

R20-6-1106. ~~Standard Medicare Supplement Benefit Plans~~ Repealed

~~**A.** An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as described in R20-6-1105(C).~~

~~**B.** No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in R20-6-1105(D)(11) and in R20-6-1107.~~

~~**C.** Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this rule and conform to the definitions in R20-6-1103. Each benefit shall be structured in accordance with the format and sequence provided in R20-6-1105(C) and (D). For purposes of this Section, "structure, language, and format" means style, arrangement and overall content of a benefit.~~

~~**D.** An issuer may use other designations, in addition to the benefit plan designations required in subsection (C) of this rule.~~

~~**E.** Format of benefit plans:~~

~~1. Standardized Medicare supplement benefit plan "A" shall be limited to the basic "core" benefits common to all benefit plans, as described in R20-6-1105(C).~~

~~2. Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefits as described in R20-6-1105(C), plus the Medicare Part A deductible as described in R20-6-1105(D)(1).~~

~~3. Standardized Medicare supplement benefit plan "C" shall include only the core benefits described in R20-6-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, and medically necessary emergency care in a foreign country described in R20-6-1105(D)(1) through (D)(3), and (D)(8).~~

~~4. Standardized Medicare supplement benefit plan "D" shall include only the core benefits described in R20-6-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and at-home recovery benefits described in R20-6-1105(D)(1), (D)(2), (D)(8), and (D)(10).~~

~~5. Standardized Medicare supplement benefit plan "E" shall include only the core benefits described in R20-6-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the preventive medical care defined in R20-6-1105(D)(1), (D)(2), (D)(8), and (D)(9).~~

~~6. Standardized Medicare supplement benefit plan "F" shall include only the core benefits described in R20-6-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as described in R20-6-1105(D)(1) through (D)(3), (D)(5), and (D)(8).~~

~~7. Standardized Medicare supplement benefit high deductible plan "F" shall include only 100% of covered expenses following the payment of the annual high deductible plan "F" deductible.~~

~~a. The covered expenses include:~~
~~i. The core benefit as defined in R20-6-1105(C),~~
~~ii. The Medicare Part A deductible,~~
~~iii. Skilled nursing facility care,~~
~~iv. The Medicare Part B deductible,~~
~~v. One hundred percent of the Medicare Part B excess charges, and~~
~~vi. Medically necessary emergency care in a foreign country as defined in R20-6-1105(D)(1) through (D)(3), (D)(5), and (D)(8).~~

~~b. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles.~~

~~c. The annual high deductible Plan "F" deductible is $1500 for 1998 and 1999, and is based on a calendar year. The~~

~~Secretary shall annually adjust the deductible to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.~~

8. ~~Standardized Medicare supplement benefit plan "G" shall include only the core benefit described in R20-6-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, 80% of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and at home recovery benefit described in R20-6-1105(D)(1), (D)(2), (D)(4), (D)(8), and (D)(10).~~
9. ~~Standardized Medicare supplement benefit plan "H" shall include only the core benefit described in R20-6-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country described in R20-6-1105(D)(1), (D)(2), (D)(6), and (D)(8).~~
10. ~~Standardized Medicare supplement benefit plan "I" shall include only the core benefit described in R20-6-1105(C), plus the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefits defined in R20-6-1105(D)(1), (D)(2), (D)(5), (D)(6), (D)(8), and (D)(10).~~
11. ~~Standardized Medicare supplement benefit plan "J" shall include only the core benefit described in R20-6-1105(C) of this Article, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100% of the Medicare Part B excess charges, extended basic prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit described in R20-6-1105(D)(1) through (D)(3), (D)(5), and (D)(7) through (D)(10).~~
12. ~~Standardized Medicare supplement benefit high deductible plan "J" shall consist of only 100% of covered expenses following the payment of the annual high deductible plan "J" deductible.~~
    a. ~~The covered expenses include:~~
        i. ~~The core benefit defined in R6-20-1105(C),~~
        ii. ~~The Medicare Part A deductible,~~
        iii. ~~Skilled nursing facility care,~~
        iv. ~~Medicare Part B deductible,~~
        v. ~~One hundred percent of the Medicare Part B excess charges,~~
        vi. ~~Extended outpatient prescription drug benefit,~~
        vii. ~~Medically necessary emergency care in a foreign county,~~
        viii. ~~Preventive medical care benefit, and~~
        ix. ~~At-home recovery benefit defined in R20-6-1105(D)(1) through (D)(3), (D)(5), and (D)(7) through (D)(10).~~
    b. ~~The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles.~~
    c. ~~The annual deductible shall be $1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.~~

R20-6-1107. ~~Medicare Select Policies and Certificates~~ Repealed

~~A.~~ ~~This rule shall apply to Medicare Select policies and certificates as defined in R20-6-1102.~~

~~B.~~ ~~No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this rule.~~

~~C.~~ ~~The director may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this rule and 42 U.S.C. 1395ss(t)(1), effective November 5, 1990, and no further amendments, incorporated herein and on file with the Office of the Secretary of State and available from the U.S. Government Printing Office, Washington, D.C., if the Director finds that the issuer has satisfied all of the requirements of this rule.~~

~~D.~~ ~~A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the director.~~

~~E.~~ ~~A Medicare Select issuer shall file a proposed plan of operation with the Director which contains at least the following information:~~

1. ~~Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:~~
    a. ~~Such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after hour care. The hours of operation and availability of after hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.~~
    b. ~~The issuer has considered the demographics of the service area in determining the number of network providers in the service area. The issuer shall further demonstrate that, with respect to current and expected policyholders, the providers in the service area will be able to either:~~

i. Deliver adequately all services that are subject to a restricted network provision; or
ii. Make appropriate referrals.
c. There are written agreements with network providers describing specific responsibilities.
d. Emergency care is available 24 hours per day and seven days per week.
e. In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

2. A statement or map providing a clear description of the service area.
3. A description of the grievance procedure to be utilized.
4. A description of the quality assurance program, including:
a. The formal organizational structure;
b. The written criteria for selection, retention and removal of network providers; and
c. The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.
5. A list and description, by specialty, of the network providers.
6. Copies of the written information proposed to be used by the issuer to comply with subsection (I) of this rule.
7. Any other information requested by the Director.

F. A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the Director prior to implementing such changes. Such changes shall be considered approved by the Director after 30 days unless specifically disapproved.
An updated list of network providers shall be filed with the Director at least quarterly.

G. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:
1. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and
2. It is not reasonable to obtain such services through a network provider.

H. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

I. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:
1. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:
a. Other Medicare supplement policies or certificates offered by the issuer; and
b. Other Medicare Select policies or certificates.
2. A description, including address, phone number and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.
3. A description of the network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized.
4. A description of coverage for emergency and urgently needed care and other out-of-service area coverage.
5. A description of limitations on referrals to restricted network providers and to other providers.
6. A description of the policyholder's rights of purchase of any other Medicare supplement policy or certificate otherwise offered by the issuer.
7. A description of the Medicare Select issuer's quality assurance program and grievance procedure.

J. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection (I) of this rule and that the applicant understands the restrictions of the Medicare Select policy or certificate.

K. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.
1. The grievance procedure shall be described in the policy and certificate and in the outline of coverage.
2. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.
3. Grievances shall be acknowledged within 15 days of receipt and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.
4. If a grievance is found to be valid, corrective action shall be taken promptly.
5. All concerned parties shall be notified about the results of a grievance.
6. The issuer shall report no later than each March 31st to the Director regarding its grievance procedure. The report shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of

such grievances.

L. At the time of initial purchase, Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

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

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

N. Medicare Select policies or certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this rule should be discontinued due to either the failure of the Medicare Select Program to be re-authorized under law or its substantial amendment.

1. Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.
2. For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purpose of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services, or coverage for Part B excess charges.

O. A Medicare Select issuer shall comply with requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

R20-6-1108. ~~Open Enrollment~~ Repealed

A. An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant who submits an application for a policy or certificate before or during the six month period beginning with the first day of the first month in which an individual is 65 years of age or older and is enrolled for benefits under Medicare Part B. Each issuer shall make available each Medicare supplement policy and certificate currently offered by the issuer to all applicants who qualify under this subsection, without regard to age.

B. An issuer shall not exclude benefits based on a preexisting condition if an applicant:

1. Qualifies under subsection (A),
2. Submits an application during the time period in subsection (A), and
3. As of the date of application, has had a continuous period of creditable coverage of at least six months.

C. If an applicant meets the criteria listed in subsections (B)(1) and (B)(2), but has had a continuous period of creditable coverage that is less than six months, an issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

D. Except as provided in subsections (B) and (C) and R20-6-1119, subsection (A) shall not be construed as preventing the exclusion of benefits under a policy or certificate, during the first six months of coverage, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

R20-6-1109. ~~Standards for Claims Payment~~ Repealed

A. An issuer shall:

1. Accept a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;
2. Notify the participating physician or supplier and the beneficiary of the payment determination;
3. Pay the participating physician or supplier directly;
4. Furnish, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a Medicare carrier may be sent;
5. Pay user fees for claim notices that are transmitted electronically or otherwise; and
6. Provide to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

~~**B.** Compliance with the requirements set forth in subsection (A) above shall be certified on the Medicare supplement insurance experience reporting form.~~

R20-6-1110. ~~Loss Ratio Standards and Refund or Credit of Premium~~ Repealed

~~**A.** Loss ratio standards.~~

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

~~a. At least 75% of the aggregate amount of premiums earned in the case of group policies; or~~

~~b. At least 65% of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses if coverage is provided by a health care services organization on a service rather than reimbursement basis, and earned premiums for the period and in accordance with accepted actuarial principles and practices.~~

~~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 policies issued before December 18, 1991, expected claims in relation to premiums shall meet:~~

~~a. The originally filed anticipated loss ratio when combined with the actual experience since inception;~~

~~b. The appropriate loss ratio requirement from subsection (A)(1) when combined with the actual experience beginning on April 28, 1996, to date; and~~

~~c. The appropriate loss ratio requirement from subsection (A)(1) 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 Director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.~~

~~2. If on the basis of the experience as reported, the benchmark ratio since inception exceeds the adjusted experience ratio since inception, 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 or certificates issued within the reporting year shall be excluded.~~

~~3. For policies or certificates issued before December 18, 1991, the issuer shall make the refund or credit calculation separately for all individual policies combined and all group policies combined for experience after April 28, 1996. The issuer shall submit the first report under this subsection by May 31, 1998.~~

~~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 .5% of the annualized premium in force as of December 31 of the reporting year. The refund or credit shall include interest from the end of the calendar year to the date of the refund or credit at a rate not 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.~~

~~1. An issuer of Medicare supplement policies or certificates issued in this state before or after the effective date of this rule shall file annually by no later than January 1 its rates, rating schedule, and supporting documentation, including ratios of incurred losses to earned premiums, by policy duration for approval by the Director. The supporting documentation shall also demonstrate, in accordance with actuarial standards of practice using reasonable assumptions, that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.~~

~~2. Before the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the Director:~~

~~a. Premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Supporting documents necessary to justify the adjustment shall accompany the filing.~~

~~i. An issuer shall make premium adjustments to produce an expected loss ratio under a policy or certificate that conforms with minimum loss ratio standards for Medicare supplement policies or certificates and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment that would modify the loss ratio experience under the policy or certificate other than the adjustments described in this subsection shall be made with respect to a policy or certificate at any time other than upon its renewal date or anniversary date.~~

~~ii. If an issuer fails to make premium adjustments in accordance with this Section, the Director may order premium adjustments, refunds, or credits deemed necessary to achieve the loss ratio required by this Section.~~

b. ~~Any riders, endorsements, or policy forms needed to modify the Medicare supplement policy or certificate to eliminate benefit duplications with Medicare. The riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.~~

~~**D.** Public hearings. The Director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this Section if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. The Director shall give notice of the hearing in accordance with A.R.S. § 20-163.~~

~~**E.** As used in this Section, "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.~~

R20-6-1111. ~~Filing and Approval of Policies and Certificates and Premium Rates~~ Repealed

~~**A.** An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the Director pursuant to A.R.S. § 20-1110.~~

~~**B.** An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Director pursuant to R20-6-1110.~~

~~**C.** Except as provided in subsection (C)(1), an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.~~

~~1. An issuer may offer, with the approval of the Director, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:~~

~~a. The inclusion of new or innovative benefits;~~

~~b. The addition of either direct response or agent marketing methods;~~

~~c. The addition of either guaranteed issue or underwritten coverage;~~

~~d. The offering of coverage to individuals eligible for Medicare by reason of disability.~~

~~2. For the purposes of this rule, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.~~

~~**D.** Except as provided in paragraph (1) of this subsection, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this Article that has been approved by the Director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.~~

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

~~2. An issuer that discontinues the availability of a policy form or certificate form pursuant to paragraph (1) of this subsection shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the Director of the discontinuance. The period of discontinuance may be reduced if the Director determines that a shorter period of time is in the best interests of the proposed applicants under the new policy form or certificate form.~~

~~3. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.~~

~~4. A change in the rating structure or methodology shall be considered a discontinuance under this Section unless the issuer complies with the following requirements:~~

~~a. The issuer provides an actuarial memorandum describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.~~

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

~~**E.** Except as provided in this subsection, the issuer shall combine the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan for purposes of the refund or credit calculation prescribed in R20-6-1110. Forms assumed under an assumption re-insurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculations.~~

R20-6-1112. ~~Permitted Compensation Requirements~~ Repealed

~~**A.** An issuer or other entity may provide commission or other compensation to an agent of other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200% of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.~~

~~**B.** The commission or other compensation provided in subsequent renewal years must be the same as the provided in the second year or period and must be provided for no fewer than five renewal years.~~

~~**C.** No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.~~

R20-6-1113. ~~Required Disclosure Provisions~~ Repealed

~~**A.** General rules.~~

~~1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the renewal or continuation provision shall be consistent with the type of contract issued. The provision shall be captioned as a renewal or continuation provision, shall appear on the first page of the policy or certificate, 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 or certificate holder'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 the date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement that 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 or coverage are required by the minimum standards for Medicare supplement policies, or the increased benefits or coverage are required by law. If a separate additional premium is charged for benefits or coverage provided in connection with riders or endorsements, the additional 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, the limitations shall appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations."~~

~~5. Medicare supplement policies and certificates shall have a notice prominently printed on or attached to the first page of the policy or certificate stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.~~

~~6. Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis, to a person eligible for Medicare shall provide to the applicant a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12-point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this Article. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request or, if not requested, no later than at the time the policy is delivered.~~

~~7. For the purposes of subsection (A)(6), "form" means language, format, type size, type proportional spacing, bold character, and line spacing.~~

~~**B.** Notice requirements.~~

~~1. As soon as practicable, but no later than 30 days before the annual effective date of any Medicare benefit change, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates. The 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, and~~

~~b. Inform each policyholder and certificate holder 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 to facilitate comprehension.~~

~~3. The notices shall not contain or be accompanied by any solicitation.~~

~~**C.** 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, issuers shall obtain an acknowledgment of receipt of the outline from the applicant.~~

~~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 that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied~~

~~for has not been issued."~~

~~3. The outline of coverage consists of four parts:~~
~~a. A cover page,~~
~~b. Premium information,~~
~~c. A disclosure page, and~~
~~d. Charts displaying the features of each benefit plan offered by the issuer.~~

~~4. The outline of coverage shall be:~~
~~a. In the language and format prescribed in Appendix B, and~~
~~b. In at least 12-point type.~~

~~5. The cover page shall:~~
~~a. Show all plans A-J, and~~
~~b. Prominently identify all plans the issuer offers.~~

~~6. The cover page or the page immediately following the cover page shall prominently display all possible premiums and modes of payment.~~

~~7. The outline of coverage shall include the items in the order prescribed in Appendix B. The information contained in the outline of coverage shall be correct as of the date of its issuance and shall include amounts payable by Medicare, the insured's deductible and what the policy or certificate pays.~~

~~**D.** Notice regarding policies or certificates that 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. 1395 et seq.), disability income policy; or other policy identified in R20-6-1101(B), issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy or certificate that the policy or certificate is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy or, if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in not less than 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 subsection (D)(1) shall provide the applicable statement in Appendix F. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.~~

R20-6-1114. ~~Requirements for Application Forms and Replacement Coverage~~ Repealed

~~**A.** Application forms shall include the questions set forth in Appendix C, designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing the questions and statements set forth in Appendix C may be used.~~

~~**B.** Agents shall list in the application any other health insurance policies they have sold to the applicant.~~
~~1. List policies sold that are still in force.~~
~~2. List policies sold in the past five years that are no longer in force.~~

~~**C.** In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the issuer, shall be returned to the applicant by the issuer upon delivery of the policy.~~

~~**D.** Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, before issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, unless the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy or certificate the notice regarding replacement of Medicare supplement coverage.~~

~~**E.** The notice required by subsection (D) shall be provided in substantially the form prescribed in Appendix D in no less than 12-point type.~~

R20-6-1115. ~~Filing Requirements for Advertising~~ Repealed

~~An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the Director of Insurance of this state for review and approval by the Director pursuant to A.R.S. § 20-1110(E).~~

R20-6-1116. ~~Standards for Marketing~~ Repealed

~~**A.** An issuer, directly or through its producers, shall:~~
~~1. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.~~

2. Establish marketing procedures to assure excessive insurance is not sold or issued.
3. Display prominently by type, stamp or other appropriate means, on the first page of the policy the following: "Notice to buyer: This policy may not cover all of your medical expenses."
4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.
5. Establish auditable procedures for verifying compliance with subsection (A) of this rule.

B. In addition to the practices prohibited in A.R.S. § 20-441 et seq., the following acts and practices are prohibited:
1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.
2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
3. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this Article.

R20-6-1117. Appropriateness of Recommended Purchase and Excessive Insurance Repealed

A. In recommending the purchase or replacement of any Medicare supplement policy or certificate, an agent shall determine the appropriateness of a recommended purchase or replacement.

B. Any sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

R20-6-1118. Report of Multiple Policies Repealed

A. On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate in the form contained in Appendix E:
1. Policy and certificate number, and
2. Date of issuance.

B. The items set forth above must be grouped by individual policyholder.

R20-6-1119. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods, and Probationary Periods in Replacement Policies or Certificates Repealed

A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

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

R20-6-1120. Separability Repealed

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Article and the application of such provision to other persons or circumstances shall not be affected thereby.

R20-6-1121. Guaranteed Issue for Eligible Persons Repealed

A. Guaranteed Issue
1. An eligible person is an individual described in subsection (B) who:
   a. Seeks to enroll under a Medicare supplement policy during the period specified in subsection (C), and
   b. Submits evidence of the date of termination or disenrollment with the application for the policy.
2. With respect to an eligible person, an issuer shall not:
   a. Deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (E) that is offered and is available for issuance to new enrollees by the issuer;
   b. Discriminate in the pricing of a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition; or
   c. Impose an exclusion of benefits based on a preexisting condition under a Medicare supplement policy.

B. Eligible Person. An eligible person is an individual described in any of the subsections (B)(1) through (B)(7):

1. The individual is enrolled under an employee welfare benefit plan that:
   a. Provides health benefits that supplement the benefits under Medicare, and
   b. Terminates or ceases to provide all supplemental health benefits to the individual;
2. The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, and any of the following circumstances apply:
   a. The organization's or plan's certification is terminated;
   b. The organization terminates or otherwise discontinues providing the plan in the area where the individual resides;
   c. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;
   d. The individual demonstrates, in accordance with guidelines established by the Secretary, that:
      i. The organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including a failure to timely provide the individual with medically necessary care for which benefits are available under the plan, or a failure to provide covered care in accordance with applicable quality standards;
      ii. The organization, agent, or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
      iii. The individual meets other exceptional conditions as the Secretary may provide;
3. 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 any of the conditions listed in subsection (B)(2) apply;
4. The individual is enrolled with an organization listed in this subsection and the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subsection (B)(2) or (B)(3):
   a. An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare risk or cost);
   b. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
   c. An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or
   d. An organization under a Medicare Select policy; and
5. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:
   a. Of the insolvency of the issuer or bankruptcy of the nonissuer organization;
   b. Of other involuntary termination of coverage or enrollment under the policy;
   c. The issuer of the policy substantially violated a material provision of the policy; or
   d. 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;
6. The individual meets both of the following conditions:
   a. The individual was enrolled under a Medicare supplement policy, terminates that enrollment, and subsequently enrolls for the first time, with:
      i. Any Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare,
      ii. Any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare risk or cost),
      iii. Any similar organization operating under demonstration project authority;
      iv. Any PACE provider under Section 1894 of the Social Security Act, or
      v. A Medicare Select policy; and
   b. The individual terminates the subsequent enrollment under subsection (B)(6) during any period within the first 12 months of the subsequent enrollment (which the enrollee is allowed to do under Section 1851(e) of the Social Security Act); or
7. The individual, upon first becoming eligible for benefits under Part A of Medicare at age 65, enrolls in a Medicare+Choice 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 not later than 12 months after the effective date of enrollment.

C. Guaranteed Issue Time Periods

1. In the case of an eligible person described in subsection (B)(1), the guaranteed issue period:
   a. Begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits, or, if a notice is not received, notice that a claim has been denied because of a termination or cessation, and
   b. Ends 63 days after the date of the applicable notice;
2. In the case of an individual described in subsections (B)(2), (B)(3), (B)(4), (B)(6) or (B)(7) whose enrollment is ter-

minated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated;

3. In the case of an individual described in subsection (B)(5)(a):
   a. The guaranteed issue period begins on the earlier of:
      i. 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, or
      ii. The date that the applicable coverage is terminated.
   b. The guaranteed issue period ends on the date that is 63 days after the date that coverage terminates;
4. In the case of an individual described in subsections (B)(2), (B)(5)(b), (B)(5)(c), (B)(6) or (B)(7) who disenrolls voluntarily, the guaranteed issue period begins on the date that is 6o 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 subsection (B) but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after that effective date.

D. Extended Medigap Access for Interrupted Trial Periods

1. In the case of an individual described in subsection (B)(6) (or deemed to be so described under this subsection) whose enrollment with an organization or provider described in subsection (B)(6)(a) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another organization or provider described in subsection (B)(6)(a), the subsequent enrollment is deemed to be an initial enrollment described in subsection (B)(6).
2. In the case of an individual described in subsection (B)(7) (or deemed to be so described under this subsection) whose enrollment with a plan or in a program described in subsection (B)(7) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another plan or program described in subsection (B)(7), the subsequent enrollment is deemed to be an initial enrollment under subsection (B)(7); and
3. For purposes of subsections (B)(6) and (B)(7), an individual's enrollment with an organization or provider described in subsection (B)(6)(a), or with a plan or in a program described in subsection (B)(7) is not considered an initial enrollment under this subsection after the two-year period beginning on the date on which the individual first enrolled with the organization, provider, plan, or program.

E. Products to Which Eligible Persons Are Entitled. An eligible person is entitled to the following Medicare supplement policy:

1. Under subsections (B)(1) through (B)(5): a Medicare supplement policy that has a benefit package classified as Plan A, B, C, or F offered by an insurer;
2. Under subsection (B)(6): the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same insurer, or, if not available, a policy described in subsection (E)(1); and
3. Under subsection (B)(7): any Medicare supplement policy offered by any insurer.

F. Notification provisions

1. At the time of an event described in subsection (B) that causes an individual to lose coverage or benefits due to the termination of a contract, 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 the individual's rights under this Section, and of the obligations of issuers of Medicare supplement policies under subsection (A). The notice shall be communicated with the notification of termination.
2. At the time of an event described in subsection (B) that causes an individual to cease enrollment under a contract, 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 the individual's rights under this Section, and of the obligations of issuers of Medicare supplement policies under subsection (A). The notice shall be communicated within 10 working days of the issuer receiving notification of disenrollment.

~~**APPENDIX A**~~

~~**MEDICARE SUPPLEMENT REFUND CALCULATION FORM**~~
~~**FOR CALENDAR YEAR**~~

~~TYPE SMSBP (W)~~

~~For the State of~~

~~Company Name~~

~~NAIC Group Code NAIC Company Code~~

~~Person Completing This Exhibit~~

~~Title Telephone Number~~

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

~~4. Refunds Lest 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~~
~~Total Earned Premium (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)~~

~~**APPENDIX A (CONT'D)**~~

~~**MEDICARE SUPPLEMENT REFUND CALCULATION FORM (continued)**~~
~~**FOR CALENDAR YEAR** _____~~

~~TYPE SMSBP (W)~~

~~For the State of~~

~~Company Name~~

~~NAIC Group Code NAIC Company Code~~

~~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 =~~ _____

~~[Total 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 December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.~~

~~**Medicare Supplement Credibility Table**~~

~~Life Years Exposed Since Inception~~	~~Tolerance~~
~~10,000 +~~	~~0. 0%~~
~~5,000 - 9,999~~	~~5.0%~~
~~2,500 - 4,999~~	~~7.5%~~
~~1,000 - 2,499~~	~~10.0%~~
~~500 - 999~~	~~15.0%~~

~~If less than 500, no credibility.~~

~~**APPENDIX A (CONT'D)**~~

~~**MEDICARE SUPPLEMENT REFUND CALCULATION FORM (continued)**~~
~~**FOR CALENDAR YEAR _____**~~

~~TYPE SMSBP (W)~~

~~For the State of~~

~~Company Name~~

~~NAIC Group Code NAIC Company Code~~

~~W = "SMSBP" = Standardized Medicare Supplement Benefit Plan~~

~~X = Includes model loadings and fees charged.~~

~~Y = Excludes Active Life Reserves.~~

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

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

_____

~~Signature~~

_____

~~Name - Please Type~~

_____

~~Title~~

_____

~~Date~~

~~**APPENDIX A (CONT'D)**~~

~~**REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES**~~
~~**FOR CALENDAR YEAR** _____~~

~~TYPE~~ _____ ~~SMSBP (P)~~ _____ _____

~~For the State of~~ _____

~~Company Name~~ _____

~~NAIC Group Code~~ _____ ~~NAIC Company Code~~ _____

~~Address~~ _____

~~Person Completing This Exhibit~~ _____

~~Title~~ _____ ~~Telephone Number~~ _____ ___

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

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

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

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

~~(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed~~

~~on this worksheet. They are shown here for informational purposes only.~~

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

~~**APPENDIX A (CONT'D)**~~

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

~~TYPE SMSBP (P)~~

~~For the State of~~

~~Company Name~~

~~NAIC Group Code NAIC Company Code~~

~~Address~~

~~Person Completing This Exhibit~~

~~Title Telephone Number~~

~~(a)~~	~~(b)~~	~~(c)~~	~~(d)~~	~~(e)~~	~~(f)~~	~~(g)~~	~~(h)~~	~~(i)~~	~~(j)~~	~~(o)~~
	~~Earned~~			~~Cumulative~~				~~Cumulative~~		~~Policy Year~~
~~Year~~	~~Premium~~	~~Factor~~	~~(b) x (c)~~	~~Loss Ratio~~	~~(d) x (e)~~	~~Factor~~	~~(b) x (g)~~	~~Loss Ratio~~	~~(h) x (i)~~	~~Loss Ratio~~
~~1~~		~~2.770~~		~~0.507~~		~~0.000~~		~~0.000~~		~~0.46~~
~~2~~		~~4.175~~		~~0.567~~		~~0.000~~		~~0.000~~		~~0.63~~
~~3~~		~~4.175~~		~~0.567~~		~~1.194~~		~~0.759~~		~~0.75~~
~~4~~		~~4.175~~		~~0.567~~		~~2.245~~		~~0.771~~		~~0.77~~
~~5~~		~~4.175~~		~~0.567~~		~~3.170~~		~~0.782~~		~~0.8~~
~~6~~		~~4.175~~		~~0.567~~		~~3.998~~		~~0.792~~		~~0.82~~
~~7~~		~~4.175~~		~~0.567~~		~~4.754~~		~~0.802~~		~~0.84~~
~~8~~		~~4.175~~		~~0.567~~		~~5.445~~		~~0.811~~		~~0.87~~
~~9~~		~~4.175~~		~~0.567~~		~~6.075~~		~~0.818~~		~~0.88~~
~~10~~		~~4.175~~		~~0.567~~		~~6.650~~		~~0.824~~		~~0.88~~
~~11~~		~~4.175~~		~~0.567~~		~~7.176~~		~~0.828~~		~~0.88~~
~~12~~		~~4.175~~		~~0.567~~		~~7.655~~		~~0.831~~		~~0.88~~
~~13~~		~~4.175~~		~~0.567~~		~~8.093~~		~~0.834~~		~~0.89~~
~~14~~		~~4.175~~		~~0.567~~		~~8.493~~		~~0.837~~		~~0.89~~
~~15~~		~~4.175~~		~~0.567~~		~~8.684~~		~~0.838~~		~~0.89~~
~~Total:~~		~~(k):~~		~~(l):~~		~~(m):~~		~~(n):~~		

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

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

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

~~(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.~~

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

~~**Appendix B. Medicare Supplement Coverage Plans**~~

~~**[12 point]**~~

~~**[COMPANY NAME]**~~

~~**OUTLINE OF MEDICARE SUPPLEMENT COVERAGE - COVER PAGE:**~~

~~**BENEFIT PLAN(s) _____[insert letter(s) of plan(s) being offered]**~~

~~Medicare supplement insurance can be sold in only ten standard Plans plus two high deductible Plans. This chart shows the benefits included in each Plan. Every company must make available Plan "A". Some Plans may not be available in [your state or Arizona].~~

~~BASIC BENEFITS: Included in all Plans.~~
~~Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.~~
~~Medical Expenses: Part B coinsurance (Generally [20]% of Medicare approved expenses), or, in the case of hospital outpatient department services under a prospective payment system, applicable copayments.~~
~~Blood: First three pints of blood each year.~~

~~A~~	~~B~~	~~C~~	~~D~~	~~E~~	~~F F*~~	~~G~~	~~H~~	~~I~~	~~J J*~~
~~Basic Benefits~~	~~Basic Benefits~~	~~Basic Benefits~~	~~Basic Benefits~~	~~Basic Benefits~~	~~Basic Benefits~~	~~Basic Benefits~~	~~Basic Benefits~~	~~Basic Benefits~~	~~Basic Benefits~~
		~~Skilled Nursing Co-Insurance~~	~~Skilled Nursing Co-Insurance~~	~~Skilled Nursing Co-Insurance~~	~~Skilled Nursing Co-Insurance~~	~~Skilled Nursing Co-Insurance~~	~~Skilled Nursing Co-Insurance~~	~~Skilled Nursing Co-Insurance~~	~~Skilled Nursing Co-Insurance~~
	~~Part A Deductible~~	~~Part A Deductible~~	~~Part A Deductible~~	~~Part A Deductible~~	~~Part A Deductible~~	~~Part A Deductible~~	~~Part A Deductible~~	~~Part A Deductible~~	~~Part A Deductible~~
		~~Part B Deductible~~			~~Part B Deductible~~				~~Part B Deductible~~
					~~Part B Excess (100%)~~	~~Part B Excess (80%)~~		~~Part B Excess (100%)~~	~~Part B Excess (100%)~~
		~~Foreign Travel Emergency~~	~~Foreign Travel Emergency~~	~~Foreign Travel Emergency~~	~~Foreign Travel Emergency~~	~~Foreign Travel Emergency~~	~~Foreign Travel Emergency~~	~~Foreign Travel Emergency~~	~~Foreign Travel Emergency~~
			~~At-Home Recovery~~			~~At-Home Recovery~~		~~At-Home Recovery~~	~~At-Home Recovery~~
							~~Basic Drugs ($1,250 Limit)~~	~~Basic Drugs ($1,250 Limit)~~	~~Extended Drugs ($3,000 Limit)~~
				~~Preventive Care~~					~~Preventive Care~~

~~* Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible Plans pay the same or offer the same benefits as Plans F and J after you have paid a calendar year [$1,620] deductible. Benefits from high deductible Plans F and J will not begin until your out-of-pocket expenses are [$1,620]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Parts A and B, but do not include, in Plan J, the Plan's separate prescription drug deductible or, in Plans F and J, the Plan's separate foreign travel emergency deductible.~~

~~**PREMIUM INFORMATION [boldface type]**~~

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

~~**DISCLOSURES [boldface type]**~~

~~Use this outline to compare benefits and premiums among policies.~~

~~**READ YOUR POLICY VERY CAREFULLY [boldface type]**~~

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

~~**RIGHT TO RETURN POLICY [boldface type]**~~

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

~~**POLICY REPLACEMENT [boldface type]**~~

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

~~**NOTICE [boldface type]**~~

~~This policy may not fully cover all of your medical costs.~~
~~[for agents] Neither [insert company's name] nor its agents are connected with Medicare.~~
~~[for direct response:] [insert company's name] is not connected with Medicare.~~
~~This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details.~~

~~**COMPLETE ANSWERS ARE VERY IMPORTANT [boldface type]**~~

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

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

~~[Include for each Plan prominently identified in the cover page a chart showing the services, Medicare payments, Plan payments, and insured payments for each Plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each Plan are included in this appendix. An issuer may use additional benefit Plan designations on these charts pursuant to R20-6-1106.]~~

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

~~**PLAN A**~~

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

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

~~**SERVICES**~~	~~**MEDICARE PAYS**~~	~~**PLAN PAYS**~~	~~**YOU PAY**~~
~~HOSPITALIZATION*~~			
~~Semiprivate room and board, general nursing and miscellaneous services and supplies~~			
~~First 60 days~~	~~All but $[812]~~	~~$0~~	~~$[812] (Part A Deductible)~~
~~61st thru 90th day~~	~~All but $[203] a day~~	~~$[203] a day~~	~~$0~~
~~91st day and after:~~			
~~- While using 60 lifetime reserve days~~	~~All but $[406] a day~~	~~$[406] 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 three 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 $[101.50]~~	~~$0~~	~~Up to $[101.50] a day~~
~~101st day and after~~	~~$0~~	~~$0~~	~~All costs~~
~~BLOOD~~			
~~First three pints~~	~~$0~~	~~three pints~~	~~$0~~
~~Additional amounts~~	~~100%~~	~~$0~~	~~$0~~
~~HOSPICE CARE~~			
~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~	~~All but very limited coinsurance for outpatient drugs and inpatient respite care~~	~~$0~~	~~Balance~~

~~**Appendix B (*Continued*) - Plan A**~~

~~**PLAN A**~~

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

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

~~SERVICES~~	~~MEDICARE PAYS~~	~~PLAN PAYS~~	~~YOU PAY~~
~~MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as~~			
~~Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,~~			
~~First $[100] of Medicare-Approved Amounts * (the Part B Deductible)~~	~~$0~~	~~$0~~	~~$[100]~~
~~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 $[100] of Medicare-Approved Amounts *~~	~~$0~~	~~$0~~	~~$[100] (Part B Deductible)~~
~~Remainder of Medicare-Approved Amounts~~	~~80%~~	~~20%~~	~~$0~~
~~CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES~~	~~$100%~~	~~$0~~	~~$0~~
	~~PARTS A & B~~		
~~HOME HEALTH CARE MEDICARE-APPROVED SERVICES~~			
~~- Medically necessary skilled care services and medical supplies~~	~~100%~~	~~$0~~	~~$0~~
~~- Durable medical equipment - First $[100] of Medicare-Approved Amounts*~~	~~$0~~	~~$0~~	~~$[100] (Part B Deductible)~~
~~Remainder of Medicare-Approved Amounts~~	~~80%~~	~~20%~~	~~$0~~

~~**PLAN B**~~

~~**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**~~

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

~~**SERVICES**~~	~~**MEDICARE PAYS**~~	~~**PLAN PAYS**~~	~~**YOU PAY**~~
~~HOSPITALIZATION*~~			
~~Semiprivate room and board, general nursing and miscellaneous services and supplies~~			
~~First 60 days~~	~~All but $[812]~~	~~$[812] (Part A Deductible)~~	~~$0~~
~~61st thru 90th day~~	~~All but $[203] a day~~	~~$[203] a day~~	~~$0~~
~~91st day and after:~~			
~~- While using 60 lifetime reserve days~~	~~All but $[406] a day~~	~~$[406] 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 three 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 $[101.50]~~	~~$0~~	~~Up to $[101.50] a day~~
~~101st day and after~~	~~$0~~	~~$0~~	~~All costs~~
~~BLOOD~~			
~~First three pints~~	~~$0~~	~~three pints~~	~~$0~~
~~Additional amounts~~	~~100%~~	~~$0~~	~~$0~~
~~HOSPICE CARE~~			
~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~	~~All but very limited coinsurance for outpatient drugs and inpatient respite care~~	~~$0~~	~~Balance~~

~~**PLAN B**~~

~~**MEDICARE (PART B) MEDICAL SERVICES; PER CALENDAR YEAR**~~

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

~~**SERVICES**~~	~~**MEDICARE PAYS**~~	~~**PLAN PAYS**~~	~~**YOU PAY**~~
~~MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,~~			
~~First $[100] of Medicare-Approved Amounts * (the Part B Deductible)~~	~~$0~~	~~$0~~	~~$[100]~~
~~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 $[100] of Medicare-Approved Amounts *~~	~~$0~~	~~$0~~	~~$[100] (Part B Deductible)~~
~~Remainder of Medicare-Approved Amounts~~	~~80%~~	~~20%~~	~~$0~~
~~CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES~~	~~100%~~	~~$0~~	~~$0~~
	~~**PARTS A & B**~~		
~~HOME HEALTH CARE MEDICARE-APPROVED SERVICES~~			
~~- Medically necessary skilled care services and medical supplies~~	~~100%~~	~~$0~~	~~$0~~
~~- Durable medical equipment First $[100] of Medicare-Approved Amounts *~~	~~$0~~	~~$0~~	~~$[100] (Part B Deductible)~~
~~Remainder of Medicare-Approved Amounts~~	~~80%~~	~~20%~~	~~$0~~

~~**PLAN C**~~
~~**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**~~

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

~~**SERVICES**~~	~~**MEDICARE PAYS**~~	~~**PLAN PAYS**~~	~~**YOU PAY**~~
~~HOSPITALIZATION*~~			
~~Semiprivate room and board, general nursing and miscellaneous services and supplies~~			
~~First 60 days~~	~~All but $[812]~~	~~$[812] (Part A Deductible)~~	~~$0~~
~~61st thru 90th day~~	~~All but $[203] a day~~	~~$[203] a day~~	~~$0~~
~~91st day and after:~~			
~~- While using 60 lifetime reserve days~~	~~All but $[406] a day~~	~~$[406] 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 three 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 $[101.50] a day~~	~~Up to $[101.50] a day~~	~~$0~~
~~101st day and after~~	~~$0~~	~~$0~~	~~All costs~~
~~BLOOD~~			
~~First three pints~~	~~$0~~	~~three pints~~	~~$0~~
~~Additional amounts~~	~~100%~~	~~$0~~	~~$0~~
~~HOSPICE CARE~~			
~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~	~~All but very limited coinsurance for outpatient drugs and inpatient respite care~~	~~$0~~	~~Balance~~

~~**PLAN C**~~
~~**MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR**~~

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

~~**SERVICES**~~	~~**MEDICARE PAYS**~~	~~**PLAN PAYS**~~	~~**YOU PAY**~~
~~MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,~~			
~~First $[100] of Medicare-Approved Amounts *~~	~~$0~~	~~$[100] (the 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 $[100] of Medicare-Approved Amounts *~~	~~$0~~	~~$[100] (Part B)~~	~~$0 (Deductible)~~
~~Remainder of Medicare-Approved Amounts~~	~~80%~~	~~20%~~	~~$0~~
~~CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES~~	~~100%~~	~~$0~~	~~$0~~
	~~**PARTS A & B**~~		
~~HOME HEALTH CARE MEDICARE-APPROVED SERVICES~~			
~~- Medically necessary skilled care services and medical supplies~~	~~100%~~	~~$0~~	~~$0~~
~~- Durable medical equipment~~			
~~- First $[100] of Medicare-Approved Amounts *~~	~~$0~~	~~$[100] (Part B Deductible)~~	~~$0~~
~~Remainder of Medicare-Approved Amounts~~	~~80%~~	~~20%~~	~~$0~~
~~FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services during the 1st 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 $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 $[812]~~	~~$[812](Part A Deductible)~~	~~$0~~
~~61st thru 90th day~~	~~All but $[203] a day~~	~~$[203] a day~~	~~$0~~
~~91st day and after:~~			
~~- While using 60 lifetime reserve days~~	~~All but $[406] a day~~	~~$[406] 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 three 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 $[101.50] a day~~	~~Up to $[101.50] a day~~	~~$0~~
~~101st day and after~~	~~$0~~	~~$0~~	~~All costs~~
~~BLOOD~~			
~~First three pints~~	~~$0~~	~~three pints~~	~~$0~~
~~Additional amounts~~	~~100%~~	~~$0~~	~~$0~~
~~HOSPICE CARE~~			
~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~	~~All but very limited coinsurance for outpatient drugs and inpatient respite care~~	~~$0~~	~~Balance~~

~~**PLAN D**~~
~~**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**~~

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

~~**SERVICES**~~	~~**MEDICARE PAYS**~~	~~**PLAN PAYS**~~	~~**YOU PAY**~~
~~MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,~~			
~~First $[100] of Medicare-Approved Amounts *~~	~~$0~~	~~$0~~	~~$[100] (the 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 $[100] of Medicare-Approved Amounts *~~	~~$0~~	~~$0~~	~~$[100] (Part B Deductible)~~
~~Remainder of Medicare-Approved Amounts~~	~~80%~~	~~20%~~	~~$0~~
~~CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES~~	~~100%~~	~~$0~~	~~$0~~
	~~**PARTS A & B**~~		
~~HOME HEALTH CARE MEDICARE-APPROVED SERVICES~~			
~~- Medically necessary skilled care services and medical supplies~~	~~100%~~	~~$0~~	~~$0~~
~~- Durable medical equipment First $[100] of Medicare-Approved Amounts *~~	~~$0~~	~~$0~~	~~$[100] (Part B Deductible)~~
~~Remainder of Medicare-Approved Amounts~~	~~80%~~	~~20%~~	~~$0~~

~~**PLAN D**~~

~~**MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR**~~

~~**SERVICES**~~	~~**MEDICARE PAYS**~~	~~**PLAN PAYS**~~	~~**YOU PAY**~~
~~AT HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE~~			
~~Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan~~			
~~- Benefit for each visit~~	~~$0~~	~~Actual Charges to $40 a visit~~	~~Balance~~
~~- Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)~~	~~$0~~	~~Up to the number of Medicare Approved visits, not to exceed 7 each week~~	
~~- Calendar year maximum~~	~~$0~~	~~$1,600~~	
	~~OTHER BENEFITS~~		
~~FOREIGN TRAVEL - NOT COVERED BY MEDICARE~~			
~~Medically necessary emergency care services during the 1st 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 $50,000 lifetime maximum~~

~~**PLAN E**~~
~~**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**~~

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

~~**SERVICES**~~	~~**MEDICARE PAYS**~~	~~**PLAN PAYS**~~	~~**YOU PAY**~~
~~HOSPITALIZATION*~~			
~~Semiprivate room and board, general nursing and miscellaneous services and supplies~~			
~~First 60 days~~	~~All but $[812]~~	~~$[812] (Part A Deductible)~~	~~$0~~
~~61st thru 90th day~~	~~All but $[203] a day~~	~~$[203] a day~~	~~$0~~
~~91st day and after:~~			
~~- While using 60 lifetime reserve days~~	~~All but $[406] a day~~	~~$[406] 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 three 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 $[101.50] a day~~	~~Up to $[101.50] a day~~	~~$0~~
~~101st day and after~~	~~$0~~	~~$0~~	~~All costs~~
~~BLOOD~~			
~~First three pints~~	~~$0~~	~~three pints~~	~~$0~~
~~Additional amounts~~	~~100%~~	~~$0~~	~~$0~~
~~HOSPICE CARE~~			
~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~	~~All but very limited coinsurance for outpatient drugs and inpatient respite care~~	~~$0~~	~~Balance~~

~~**PLAN E**~~
~~**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**~~

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

~~**SERVICES**~~	~~**MEDICARE PAYS**~~	~~**PLAN PAYS**~~	~~**YOU PAY**~~
~~MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,~~			
~~First $[100] of Medicare-Approved Amounts * (the Part B Deductible)~~	~~$0~~	~~$0~~	~~$[100] (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 $[100] of Medicare-Approved Amounts *~~	~~$0~~	~~$0~~	~~$[100] (Part B Deductible)~~
~~Remainder of Medicare-Approved Amounts~~	~~80%~~	~~20%~~	~~$0~~
~~CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES~~	~~100%~~	~~$0~~	~~$0~~
	~~**PARTS A & B**~~		
~~HOME HEALTH CARE MEDICARE-APPROVED SERVICES~~			
~~- Medically necessary skilled care services and medical supplies~~	~~100%~~	~~$0~~	~~$0~~
~~- Durable medical equipment~~			
~~- First $[100] of Medicare-Approved Amounts *~~	~~$0~~	~~$0~~	~~$[100] (Part B Deductible)~~
~~Remainder of Medicare-Approved Amounts~~	~~80%~~	~~20%~~	~~$0~~

Appendix B (*Continued*) - Plan E

PLAN E

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OTHER BENEFITS			
*PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE			
Some annual physical and preventive tests and services, such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education administered or ordered by your doctor when not covered by Medicare			
- First $120 each calendar year	$0	$120	$0
- Additional charges	$0	$0	All costs

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

FOREIGN TRAVEL - NOT COVERED BY MEDICARE

Medically necessary emergency care services during the 1st 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 $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 or offers the same benefits as Plan F after you have paid a calendar year [$1,620] deductible. Benefits from the high deductible Plan F will not begin until your out-of-pocket expenses are [$1,620]. 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 $1620 DEDUCTIBLE** PLAN PAYS**~~	~~**IN ADDITION TO $1620 DEDUCTIBLE** YOU PAY**~~
~~HOSPITALIZATION*~~			
~~Semiprivate room and board, general nursing and miscellaneous services and supplies~~			
~~First 60 days~~	~~All but $[812]~~	~~$[812] (Part A Deductible)~~	~~$0~~
~~61st thru 90th day~~	~~All but $[203] a day~~	~~$[203] a day~~	~~$0~~
~~91st day and after:~~			
~~- While using 60 lifetime reserve days~~	~~All but $[406] a day~~	~~$[406] 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 three 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 $[101.50] a day~~	~~Up to $[101.50] a day~~	~~$0~~
~~101st day and after~~	~~$0~~	~~$0~~	~~All costs~~
~~BLOOD~~			
~~First three pints~~	~~$0~~	~~three pints~~	~~$0~~
~~Additional amounts~~	~~100%~~	~~$0~~	~~$0~~
~~HOSPICE CARE~~			
~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~	~~All but very limited coinsurance for outpatient drugs and inpatient respite care~~	~~$0~~	~~Balance~~

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

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

**This high deductible Plan pays the same or offers the same benefits as Plan F after you have paid a calendar year [$1,620] deductible. Benefits from the high deductible Plan F will not begin until your out-of-pocket expenses are [$1,620]. 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 $1620 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $1620 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 $[100] of Medicare-Approved Amounts*	$0	$[100] (the Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First three pints	$0	All costs	$0
Next $[100] of Medicare-Approved Amounts*	$0	$[100] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-BLOOD - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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

	OTHER BENEFITS NOT COVERED BY MEDICARE		
SERVICES	**MEDICARE PAYS**	**AFTER YOU PAY $1620 DEDUCTIBLE** PLAN PAYS**	**IN ADDITION TO $1620 DEDUCTIBLE** YOU PAY**
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 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 $50,000 lifetime maximum

~~**PLAN G**~~
~~**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**~~

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

~~**SERVICES**~~	~~**MEDICARE PAYS**~~	~~**PLAN PAYS**~~	~~**YOU PAY**~~
~~HOSPITALIZATION*~~			
~~Semiprivate room and board, general nursing and miscellaneous services and supplies~~			
~~First 60 days~~	~~All but $[812]~~	~~$[812] (Part A Deductible)~~	~~$0~~
~~61st thru 90th day~~	~~All but $[203] a day~~	~~$[203] a day~~	~~$0~~
~~91st day and after:~~			
~~- While using 60 lifetime reserve days~~	~~All but $[406] a day~~	~~$[406] 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 three 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 $[101.50] a day~~	~~Up to $[101.50] a day~~	~~$0~~
~~101st day and after~~	~~$0~~	~~$0~~	~~All costs~~
~~BLOOD~~			
~~First three pints~~	~~$0~~	~~three pints~~	~~$0~~
~~Additional amounts~~	~~100%~~	~~$0~~	~~$0~~
~~HOSPICE CARE~~			
~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~	~~All but very limited coinsurance for outpatient drugs and inpatient respite care~~	~~$0~~	~~Balance~~

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

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

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

PARTS A & B

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

Appendix B (*Continued*) - Plan G

PLAN G

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	
- Calendar year maximum	$0	$1,600	
OTHER BENEFITS			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 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 $50,000 lifetime maximum

~~**PLAN H**~~
~~**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**~~

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

~~**SERVICES**~~	~~**MEDICARE PAYS**~~	~~**PLAN PAYS**~~	~~**YOU PAY**~~
~~HOSPITALIZATION*~~			
~~Semiprivate room and board, general nursing and miscellaneous services and supplies~~			
~~First 60 days~~	~~All but $[812]~~	~~$[812] (Part A Deductible)~~	~~$0~~
~~61st thru 90th day~~	~~All but $[203] a day~~	~~$[203] a day~~	~~$0~~
~~91st day and after:~~			
~~– While using 60 lifetime reserve days~~	~~All but $[406] a day~~	~~$[406] 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 three 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 $[101.50] a day~~	~~Up to $[101.50] a day~~	~~$0~~
~~101st day and after~~	~~$0~~	~~$0~~	~~All costs~~
~~BLOOD~~			
~~First three pints~~	~~$0~~	~~three pints~~	~~$0~~
~~Additional amounts~~	~~100%~~	~~$0~~	~~$0~~
~~HOSPICE CARE~~			
~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~	~~All but very limited coinsurance for outpatient drugs and inpatient respite care~~	~~$0~~	~~Balance~~

~~**PLAN H**~~

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

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

~~**SERVICES**~~	~~**MEDICARE PAYS**~~	~~**PLAN PAYS**~~	~~**YOU PAY**~~
~~MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as~~			
~~Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,~~			
~~First $[100] of Medicare-Approved Amounts * (the Part B Deductible)~~	~~$0~~	~~$0~~	~~$[100]~~
~~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 $[100] of Medicare-Approved Amounts *~~	~~$0~~	~~$0~~	~~$[100] (Part B Deductible)~~
~~Remainder of Medicare-Approved Amounts~~	~~80%~~	~~20%~~	~~$0~~
~~CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES~~	~~100%~~	~~$0~~	~~$0~~
	~~**PARTS A & B**~~		
~~HOME HEALTH CARE MEDICARE-APPROVED SERVICES~~			
~~- Medically necessary skilled care services and medical supplies~~	~~100%~~	~~$0~~	~~$0~~
~~- Durable medical equipment~~			
~~- First $[100] of Medicare-Approved Amounts *~~	~~$0~~	~~$0~~	~~$[100] (Part B Deductible)~~
~~- Remainder of Medicare-Approved Amounts~~	~~80%~~	~~20%~~	~~$0~~

~~**Appendix B (*Continued*) - Plan H**~~

~~**PLAN H**~~
~~**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**~~

~~**OTHER BENEFITS**~~

~~**SERVICES**~~	~~**MEDICARE PAYS**~~	~~**PLAN PAYS**~~	~~**YOU PAY**~~
~~BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE~~			
~~First $250 each calendar year~~	~~$0~~	~~$0~~	~~$250~~
~~Next $2,500 each calendar year~~	~~$0~~	~~50% - $1,250 calendar year maximum benefit~~	~~50%~~
~~Over $2,500 each calendar year~~	~~$0~~	~~$0~~	~~All costs~~
~~FOREIGN TRAVEL - NOT COVERED BY MEDICARE~~			
~~Medically necessary emergency care services during the 1st 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 $50,000 lifetime maximum~~

~~**PLAN I**~~
~~**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**~~

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

~~**SERVICES**~~	~~**MEDICARE PAYS**~~	~~**PLAN PAYS**~~	~~**YOU PAY**~~
~~HOSPITALIZATION*~~			
~~Semiprivate room and board, general nursing and miscellaneous services and supplies~~			
~~First 60 days~~	~~All but $[812]~~	~~$[812] (Part A Deductible)~~	~~$0~~
~~61st thru 90th day~~	~~All but $[203] a day~~	~~$[203] a day~~	~~$0~~
~~91st day and after:~~			
~~- While using 60 lifetime reserve days~~	~~All but $[406] a day~~	~~$[406] 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 three 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 $[101.50] a day~~	~~Up to $[101.50] a day~~	~~$0~~
~~101st day and after~~	~~$0~~	~~$0~~	~~All costs~~
~~BLOOD~~			
~~First three pints~~	~~$0~~	~~three pints~~	~~$0~~
~~Additional amounts~~	~~100%~~	~~$0~~	~~$0~~
~~HOSPICE CARE~~			
~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~	~~All but very limited coinsurance for outpatient drugs and inpatient respite care~~	~~$0~~	~~Balance~~

~~**PLAN I**~~

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

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

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

~~**PARTS A & B**~~

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

Appendix B (*Continued*) - Plan I

PLAN I

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number Medicare-Approved visits, not to exceed 7 each week	
- Calendar year maximum	$0	$1,600	
OTHER BENEFITS			
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50% - $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 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 $50,000 lifetime maximum

~~**PLAN J or HIGH DEDUCTIBLE PLAN J**~~
~~**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**~~

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

~~**This high deductible Plan pays the same or offers the same benefits as Plan J after you have paid a calendar year [$1,620] deductible. Benefits from the high deductible Plan J will not begin until your out-of-pocket expenses are [$1,620]. 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 prescription drug deductible or the Plan's separate foreign travel emergency deductible.~~

~~**SERVICES**~~	~~**MEDICARE PAYS**~~	~~**AFTER YOU PAY $1620 DEDUCTIBLE** PLAN PAYS**~~	~~**IN ADDITION TO $1620 DEDUCTIBLE** YOU PAY**~~
~~HOSPITALIZATION*~~			
~~Semiprivate room and board, general nursing and miscellaneous services and supplies~~			
~~First 60 days~~	~~All but $[812]~~	~~$[812] (Part A Deductible)~~	~~$0~~
~~61st thru 90th day~~	~~All but $[203] a day~~	~~$[203] a day~~	~~$0~~
~~91st day and after:~~			
~~- While using 60 lifetime reserve days~~	~~All but $[406] a day~~	~~$[406] 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 three 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 $[101.50] a day~~	~~Up to $[101.50] a day~~	~~$0~~
~~101st day and after~~	~~$0~~	~~$0~~	~~All costs~~
~~BLOOD~~			
~~First three pints~~	~~$0~~	~~three pints~~	~~$0~~
~~Additional amounts~~	~~100%~~	~~$0~~	~~$0~~
~~HOSPICE CARE~~			
~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~	~~All but very limited coinsurance for outpatient drugs and inpatient respite care~~	~~$0~~	~~Balance~~

~~**PLAN J or HIGH DEDUCTIBLE PLAN J**~~
~~**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**~~

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

~~**This high deductible Plan pays the same or offers the same benefits as Plan J after you have paid a calendar year [$1,620] deductible. Benefits from the high deductible Plan J will not begin until your out-of-pocket expenses are [$1,620] 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 prescription drug deductible or the Plan's separate foreign travel emergency deductible.~~

~~**SERVICES**~~	~~**MEDICARE PAYS**~~	~~**AFTER YOU PAY $1620 DEDUCTIBLE** PLAN PAYS**~~	~~**IN ADDITION TO $$1620 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 $[100] of Medicare-Approved Amounts* $0 (the Part B Deductible)~~		~~$[100]~~	~~$0~~
~~Remainder of Medicare-Approved Amounts~~	~~Generally 80%~~	~~Generally 20%~~	~~$0~~
~~Part B Excess Charges (Above Medicare-Approved Amounts)~~	~~$0~~	~~100%~~	~~$0~~
~~BLOOD~~			
~~First three pints~~	~~$0~~	~~All costs~~	~~$0~~
~~Next $[100] of Medicare-Approved Amounts*~~	~~$0~~	~~$[100] (Part B Deductible)~~	~~$0~~
~~Remainder of Medicare-Approved Amounts~~	~~80%~~	~~20%~~	~~$0~~
~~CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES~~	~~100%~~	~~$0~~	~~$0~~
	~~**PARTS A & B**~~		
~~HOME HEALTH CARE MEDICARE-APPROVED SERVICES~~			
~~- Medically necessary skilled care services and medical supplies~~	~~100%~~	~~$0~~	~~$0~~
~~- Durable medical equipment~~			
~~First $[100] of Medicare-Approved Amounts *~~	~~$0~~	~~$[100] (Part B Deductible)~~	~~$0~~
~~Remainder of Medicare-Approved Amounts~~	~~80%~~	~~20%~~	~~$0~~

~~**PLAN J or HIGH DEDUCTIBLE PLAN J**~~
~~**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**~~

~~SERVICES~~	~~MEDICARE PAYS~~	~~AFTER YOU PAY $1620 DEDUCTIBLE** PLAN PAYS~~	~~IN ADDITION TO $1620 DEDUCTIBLE** YOU PAY~~
~~AT HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE~~			
~~Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan~~			
~~- Benefit for each visit~~	~~$0~~	~~Actual Charges to $40 a visit~~	~~Balance~~
~~- Number of visits covered (must be received within eight weeks of last Medicare-Approved visit)~~	~~$0~~	~~Up to the number of Medicare-Approved visits, not to exceed seven each week~~	
~~- Calendar year maximum~~	~~$0~~	~~$1,600~~	

~~**OTHER BENEFITS - NOT COVERED BY MEDICARE**~~

~~SERVICES~~	~~MEDICARE PAYS~~	~~AFTER YOU PAY $1620 DEDUCTIBLE** PLAN PAYS~~	~~IN ADDITION TO $1620 DEDUCTIBLE** YOU PAY~~
~~EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE~~			
~~First $250 each calendar year~~	~~$0~~	~~$0~~	~~$250~~
~~Next $6,000 each calendar year~~	~~$0~~	~~50% - $3,000 calendar year maximum benefit~~	~~50%~~
~~Over $6,000 each calendar year~~	~~$0~~	~~$0~~	~~All costs~~
~~***PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE~~			
~~Some annual physical and preventive tests and services, such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education administered or ordered by your doctor when not covered by Medicare~~			
~~- First $120 each calendar year~~	~~$0~~	~~$120~~	~~$0~~
~~- Additional charges~~	~~$0~~	~~$0~~	~~All costs~~

~~SERVICES~~	~~MEDICARE PAYS~~	~~PLAN PAYS~~	~~YOU PAY~~
	~~OTHER BENEFITS (*Continued*)~~		
~~FOREIGN TRAVEL - NOT COVERED BY MEDICARE~~			
~~Medically necessary emergency care services 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 $50,000 lifetime maximum~~

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

~~**APPENDIX C**~~

~~[Statements]~~

1. ~~You do not need more than one Medicare supplement policy.~~
2. ~~If you purchase this policy, you may want to evaluate your existing health coverage and decide whether you need multiple coverages.~~
3. ~~You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.~~
4. ~~The benefits and premiums under your Medicare supplement policy can be suspended for 24 months, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.~~
5. ~~Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).~~

~~[Questions]~~

~~To the best of your knowledge,~~

1. ~~Do you have another Medicare supplement policy or certificate in force?~~
   a. ~~If so, with which company?~~
   b. ~~If so, do you intend to replace your current Medicare supplement policy with this policy [certificate]?~~
2. ~~Do you have any other health insurance coverages that provide benefits similar to this Medicare supplement policy [certificate]?~~
   a. ~~If so, with which company?~~
   b. ~~What kind of policy?~~
3. ~~Are you covered for medical assistance through the state Medicaid program:~~
   a. ~~As a Specified Low Income Medicare Beneficiary (SLMB)?~~
   b. ~~As a Qualified Medicare Beneficiary (QMB)?~~
   c. ~~For full Medicaid Benefits?~~

~~**APPENDIX D**~~

~~**NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE**~~

~~**[Insurance company's name and address]**~~

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

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

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

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

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

~~_____ Additional benefits~~

~~_____ No change in benefits, but lower premiums~~

~~_____ Fewer benefits and lower premiums~~

~~_____ Other (please specify)_____~~

~~_____~~

~~_____~~

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

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

_____

~~(Signature of Agent, Broker or Other Representative)*~~

~~[Typed Name and Address of Issuer, Agent or Broker]~~

_____

~~(Applicant's Signature)~~

_____

~~(Date)~~

~~*Signature not required for direct response sales.~~

~~**APPENDIX E**~~

~~**FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES**~~

~~Company Name:~~ _____

~~Address:~~ _____

_____

~~Phone Number:~~ _____

~~**Due: March 1, annually**~~

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

~~**Policy and Certificate Number**~~	~~**Date of Issuance**~~

_____

~~Signature~~

_____

~~Name and Title (please type)~~

_____

~~Date~~

~~**Appendix F. Medicare Disclosure Statements**~~

~~**MEDICARE DISCLOSURE STATEMENTS**~~

~~**Instructions for use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries**~~

~~1. 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).~~

~~2. State and Federal law prohibits insurers from selling a Medicare supplement policy to a person who already has a Medicare supplement policy except as a replacement policy.~~

~~3. Property/Casualty and Life insurance policies are not considered health insurance.~~

~~4. Disability income policies are not considered to provide benefits that duplicate Medicare.~~

~~5. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.~~

~~6. The federal law does not preempt state laws that are more stringent than the federal requirements.~~

~~7. The federal law does not preempt existing state form filing requirements.~~

~~8. 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 F 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.~~

Appendix F. Medicare Disclosure Statements *(Continued)*

[Original 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 under 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
- 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 senior insurance counseling program.

~~**Appendix F. Medicare Disclosure Statements *(Continued)***~~

~~[Original 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 under 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~~
- ~~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 senior insurance counseling program.~~

Appendix F. Medicare Disclosure Statements *(Continued)*

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. 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 under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for 1 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
- 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 senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Original disclosure statement for policies that pay fixed dollar amounts for a specified disease or diseases or a specified impairment or 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 under this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for 1 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
- 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 senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[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 IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under 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
- 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 senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[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

Some health care services paid for by Medicare may also trigger the payment of benefits under 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
- 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 senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Original disclosure statement for other health insurance policies not specifically identified in the preceding 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 under 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
- 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 senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for policies that provide benefits incurred for an accident 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 under 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
- 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 senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[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 under 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 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
- 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 senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. 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
- 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 senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[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
- 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 senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[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
- 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 senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[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
- 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 senior insurance counseling program.

Appendix F. Medicare Disclosure Statements *(Continued)*

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding 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 policy 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
- 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 senior insurance counseling program.