COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
OFFICE OF SPECIAL PROJECTS
1326 Strawberry Square
Harrisburg, PA 17120

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SENT BY FAX AND MAIL

October 31, 2000

Original: 2152

Mr. Robert Nyce
Executive Director
Independent Regulatory Review Comm.
333 Market Street
Harrisburg, PA 17101

Re: Insurance Department Final Form Regulation No. 11-205, Medicare Supplement Insurance Minimum Standards

Dear Mr. Nyce:

The Insurance Department is hereby withdrawing regulation number 11-205, Medicare Supplement Insurance Minimum Standards, from consideration at this time. This rulemaking was delivered on October 3, 2000.

If you have any questions regarding this matter, please contact me at (717) 787-4429.

Sincerely yours,

Peter J. Salvatore
Regulatory Coordinator

11-205w

Regulatory Analysis Form

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REVIEW COMMISSION

(1) Agency

Insurance Department

(2) I.D. Number (Governor's Office Use)

11-205

IRRC Number: 2152

(3) Short Title

Medicare Supplement Insurance Minimum Standards

(4) PA Code Cite

31 Pa. Code, Chapter 89, §§89.772, 89.776, 89.783 and 89.790

(5) Agency Contacts & Telephone Numbers

Primary Contact: Peter J. Salvatore, Regulatory Coordinator, 1326 Strawberry Square, Harrisburg, PA 17120, (717) 787-4429

Secondary Contact:

(6) Type of Rulemaking (check one)

- ☐ Proposed Rulemaking
- ☐ Final Order Adopting Regulation
- ☒ Final Order, Proposed Rulemaking Omitted

(7) Is a 120-Day Emergency Certification Attached?

- ☒ No
- ☐ Yes: By the Attorney General
- ☐ Yes: By the Governor

(8) Briefly explain the regulation in clear and nontechnical language.

The amendments will bring the Department's regulation for the approval of Medicare supplement policies into compliance with the federal statutory requirements of the Social Security Act (42 U.S.C.A §1395ss), the Balanced Budget Refinement Act of 1999 (P.L. 106-170) and Ticket to Work and Work Incentives Improvement Act (P.L. 106-113).

(9) State the statutory authority for the regulation and any relevant state or federal court decisions.

Sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P.S. §§ 66, 186, 411, and 412) and the federal statutory requirements of the Social Security Act (42 U.S.C.A §1395ss), the Balanced Budget Refinement Act of 1999 (P.L. 106-170) and Ticket to Work and Work Incentives Improvement Act (P.L. 106-113).

Regulatory Analysis Form

(10) Is the regulation mandated by any federal or state law or court order, or federal regulation? If yes, cite the specific law, case or regulation, and any deadlines for action.

The federal statutory requirements of the Social Security Act (42 U.S.C.A §1395ss), the Balanced Budget Refinement Act of 1999 (P.L. 106-170) and Ticket to Work and Work Incentives Improvement Act (P.L. 106-113). The Balanced Budget Refinement Act of 1999 (P.L. 106-170) was effective November 29, 1999 and the Ticket to Work and Work Incentives Improvement Act (P.L. 106-113) was effective December 17, 1999. Both of these statutes provided states with a 1-year timetable in order to comply with the federal requirements.

(11) Explain the compelling public interest that justifies the regulation. What is the problem it addresses?

The Insurance Department seeks to amend Chapter 89 to be consistent with the authorizing statute.

(12) State the public health, safety, environmental or general welfare risks associated with nonregulation.

There are no public health, safety, environment or general welfare risks associated with this rulemaking.

(13) Describe who will benefit from the regulation. (Quantify the benefits as completely as possible and approximate the number of people who will benefit.)

Any person who purchases a Medicare Supplement policy will benefit from the regulation to the extent that it will be consistent with the statute.

Regulatory Analysis Form

(14) Describe who will be adversely affected by the regulation. (Quantify the adverse effects as completely as possible and approximate the number of people who will be adversely affected.)

There will be no adverse effects on any party because of the amendment of this regulation.

(15) List the persons, groups or entities that will be required to comply with the regulation. (Approximate the number of people who will be required to comply.)

The regulation applies to all insurers licensed to do business of Medicare Supplement policies in the Commonwealth.

(16) Describe the communications with and input from the public in the development and drafting of the regulation. List the persons and/or groups who were involved, if applicable.

No comments regarding the amendment of this regulation were solicited from the various trade associations representing the insurance industry.

(17) Provide a specific estimate of the costs and/or savings to the regulated community associated with compliance, including any legal, accounting or consulting procedures, which may be required.

The amendment of the regulation will not have any impact on costs associated with insurance companies. Insurers will need to meet these requirements under the federal statute if the Commonwealth does not have a regulation in place by the end of the year 2000.

Regulatory Analysis Form

(18) Provide a specific estimate of the costs and/or savings to local governments associated with compliance, including any legal, accounting or consulting procedures, which may be required.

There are no costs or savings to local governments associated with this rulemaking.

(19) Provide a specific estimate of the costs and/or savings to state government associated with the implementation of the regulation, including any legal, accounting, or consulting procedures, which may be required.

There are no costs or savings associated to state government associated with this rulemaking.

Regulatory Analysis Form

(20) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years. N/A

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS:	$	$	$	$	$	$
Regulated Community						
Local Government						
State Government						
Total Savings						
COSTS:						
Regulated Community						
Local Government						
State Government						
Total Costs						
REVENUE LOSSES:						
Regulated Community						
Local Government						
State Government						
Total Revenue Losses						

(20a) Explain how the cost estimates listed above were derived.

N/A.

Regulatory Analysis Form

(20b) Provide the past three-year expenditure history for programs affected by the regulation.
N/A.

Program	FY -3	FY -2	FY -1	Current FY

(21) Using the cost-benefit information provided above, explain how the benefits of the regulation outweigh the adverse effects and costs.

No costs or adverse effects are anticipated as a result of this regulation.

(22) Describe the nonregulatory alternatives considered and the costs associated with those alternatives. Provide the reasons for their dismissal.

Amending Chapter 89 is the most efficient method to achieve consistency with the authorizing statute. No other alternatives were considered.

(23) Describe alternative regulatory schemes considered and the costs associated with those schemes. Provide the reasons for their dismissal.

No other regulatory schemes were considered. The amendment of the regulation is the most efficient method of updating the regulatory requirements.

Regulatory Analysis Form

(24) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulation.

No.

(25) How does this regulation compare with those of other states? Will the regulation put Pennsylvania at a competitive disadvantage with other states?

The rulemaking will not put Pennsylvania at a competitive disadvantage with other states. It merely provides for consistency with the statute.

(26) Will the regulation affect existing or proposed regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

No.

(27) Will any public hearings or informational meetings be scheduled? Please provide the dates, times, and locations, if available.

No public hearings or informational meetings are anticipated.

Regulatory Analysis Form

(28) Will the regulation change existing reporting, record keeping, or other paperwork requirements? Describe the changes and attach copies of forms or reports, which will be required as a result of implementation, if available.

The amendment of the regulation imposes no additional paperwork requirements on the Department, insurers or the public.

(29) Please list any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers.

The rulemaking will have no effect on special needs of affected parties.

(30) What is the anticipated effective date of the regulation; the date by which compliance with the regulation will be required; and the date by which any required permits, licenses or other approvals must be obtained?

The rulemaking will undergo a 30-day review by the legislative standing committees, the Office of the Attorney General, and the Independent Regulatory Review Commission and will take effect upon approval of the final form regulation and upon final publication in the *Pennsylvania Bulletin.*

(31) Provide the schedule for continual review of the regulation.

The Department reviews each of its regulations for continued effectiveness on a triennial basis.

CDL-1

FACE SHEET FOR FILING DOCUMENTS WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

#2152

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REVIEW COMMISSION

DO NOT WRITE IN THIS SPACE

Copy below is hereby approved as to form and legality Attorney General	Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by.	Copy below is hereby approved as to form and legality Executive or Independent Agencies
By _____ (Deputy Attorney General)	Insurance Department (AGENCY)	BY: _____
_____ Date of Approval	DOCUMENT/FISCAL NOTE NO. 11-205	10/3/00 DATE OF APPROVAL
	DATE OF ADOPTION: _____	(DEPUTY GENERAL COUNSEL) (~~CHIEF COUNSEL, INDEPENDENT AGENCY~~) (STRIKE INAPPLICABLE TITLE)
→ Check if applicable. Copy not approved. Objections attached.	BY: M. Diane Koken M. Diane Koken Insurance Commissioner	→ Check if applicable. No Attorney General approval or objection within 30 days after submission.
	TITLE: _____ (EXECUTIVE OFFICER, CHAIRMAN OR SECRETARY)	

NOTICE OF FINAL-OMITTED RULEMAKING

INSURANCE DEPARTMENT

31 Pa. Code, Chapter 89 §§89.772, 89.776,89.783 and 89.790

Medicare Supplement Insurance Minimum Standards

PREAMBLE

By this notice the Insurance Department (Department) hereby amends 31 Pa. Code, Chapter 89, Subchapter K, Medicare Supplement Insurance Minimum Standards, sections 89.772, 89.776, 89.783, and 89.790 to read as set forth in Annex A. Sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P.S. §§ 66, 186, 411, and 412) provide the Insurance Commissioner with the authority and duty to promulgate regulations governing the enforcement of the laws relating to insurance.

Notice of the proposed rulemaking is omitted in accordance with section 204(3) of the act of July 31, 1968 (P.L. 769, No. 240) known as the Commonwealth Documents Law (CDL) (45 P.S. § 1204(3)). In accordance with section 204(3) of the CDL, notice of proposed rulemaking may be omitted when the agency for good cause finds that public notice of its intention to amend an administrative regulation is, under the circumstances, impracticable and unnecessary.

Purpose

The amendments will bring the Department's regulation for the approval of Medicare supplement policies into compliance with the federal statutory requirements of the Social Security Act (42 U.S.C.A. §1395ss), the Balanced Budget Refinement Act of 1999 (P.L. 106-170) and the Ticket to Work and Work Incentives Improvement Act (P.L. 106-113).

The changes, indicated to Subchapter K, are federally mandated under recent federal legislation, the Balanced Budget Refinement Act of 1999, with a November 29, 1999 effective date and the Ticket to Work and Work Incentives Improvement Act, with a December 17, 1999 effective date. The federal law also establishes a timetable under which these changes are to be implemented by the states if they are to remain in compliance with the federal requirements and maintain regulatory authority in this area. The new regulations must be adopted within one year (two in specified cases) following the NAIC adoption of the model regulations. In order to comply with federal statutory minimum requirements for Medicare supplement policies, as mandated by sections 501 (a) and 536 of the Balanced Budget Refinement Act of 1999, and the Ticket to Work and Work Incentives Improvement Act, section 205, the Insurance Commissioner finds that the proposed rulemaking procedures in sections 201 and 202 of the CDL (45 P.S. §§1201 and 1202) are impracticable and unnecessary in this situation, and that the proposed rulemaking may be properly omitted under section 204(3) of the CDL (45 P.S. §1204(3)).

Subchapter K of Chapter 89 was initially promulgated to establish minimum standards for Medicare supplement insurance policies. Standardization of policies was federally required under the Omnibus Budget Reconciliation Act of 1990. The Insurance Department currently seeks to modify Subchapter K to meet the new federal mandates for Medicare supplement policies as required under the Balanced Budget Refinement Act of 1999 (P.L. 106-170) and the Ticket to Work and Work Incentives Improvement Act (P.L. 106-113).

These amendments are necessary to maintain Pennsylvania's compliance with federal requirements, which will ensure that Pennsylvania retains enforcement authority over these new requirements. These standards will be implemented through federal preemption if Pennsylvania does not implement these changes through state regulation within one year (two in specified cases) after NAIC adoption. The federal legislation establishes that states which adopt the language of the NAIC Medicare Supplement model regulation, which has been revised to address the federal changes, will be considered to be in compliance with the federal requirements.

These amendments will protect the rights of Pennsylvania consumers purchasing Medicare supplement policies.

Explanation of Regulatory Requirements

Section 89.772 (relating to definitions) has been amended to include the United States Code citation. The added language to Medicare + Choice is based on the revised NAIC Medicare Supplement model regulation.

Section 89.776 (relating to benefit standards) has been modified. Section 89.776 (1)(vii)(C) has been revised to reflect the new federal requirements under the Ticket to Work and Work Incentives Improvement Act (P.L. 106-113) amending the suspension of benefits and premiums under a Medicare Supplement policy due to coverage under a group health plan. The new language is based on the revised NAIC Medicare Supplement model regulation.

Section 89.776 (2)(v) (relating to core benefit standards) has been amended to reflect the new payment system for Medicare outpatient hospital services. The new language is based on the revised NAIC Medicare Supplement model regulation.

Section 89.776 (3)(ix)(B) (relating to additional benefit standards) has been amended to reflect changes to the preventive medical care benefit. The fecal occult blood and a mammogram test are being deleted. This correction is a result of the Balanced Budget Refinement Act of 1999 adding coverage to Medicare Part B and should not be included in benefits covered under a Medicare Supplement policy. This new language is based on the revised NAIC Medicare Supplement model regulation.

Section 89.776 (3)(ix)(C) (relating to additional benefit standards) has been amended to reflect changes to the preventive medical care benefit. The influenza vaccination is being deleted here and moved to the basic services. This correction is a result of the Balanced Budget Refinement Act of 1999 adding coverage to the Medicare Part B and should not be included in benefits covered under a Medicare Supplement policy. This new language is based on the revised NAIC Medicare Supplement model regulation.

Section 89.783 (a)(6) (relating to required disclosure) has been amended to italicize the name of the *Guide to Health Insurance for People with Medicare*, and the word *Guide* in italics

and underline is being used as an abbreviation. The new language is based on the revised NAIC Medicare Supplement model regulation.

Section 89.783 (c)(5) (relating to the required outline of coverage disclosure) has been amended to correctly title the Medicare handbook to "Medicare & You". Changes to the outline of coverages in outpatient services and plan specific deductibles are being changed. The new language is based on the revised NAIC Medicare Supplement model regulation.

Section 89.790 (a)(1) (relating to guaranteed issue for eligible persons) has been changed to broaden the definition of an eligible person as set forth in (a)(2) and (b)(1) to meet new federal requirements under the Balanced Budget Refinement Act of 1999. The new language is based on the revised NAIC Medicare Supplement model regulation.

Section 89.790 (b)(2) (relating to eligible persons) expands the class of persons eligible for guaranteed issue to include individuals who are 65 years of age or older and enrolled in the Program of All-inclusive Care for the Elderly (PACE). The language is a result of section 536 of the Balanced Budget Refinement Act of 1999. This language was adopted by the NAIC model regulation.

Section 89.790 (b)(2)(vi) and (vi) (relating to eligible persons) is being amended to provide that a beneficiary may elect to begin his or her guaranteed issue period upon receipt of notification of impending termination of a Medicare+Choice plan. This establishes that a beneficiary does not have to wait until actual termination of the Medicare+Choice plan to apply and receive a guaranteed issue Medicare Supplement policy. This language is a result of section 501(a) of the Balanced Budget Refinement Act of 1999. This language is based on the revised NAIC model regulation.

Section 89.790 (b)(5) (relating to termination of enrollment) adds any PACE program under section 1894 of the SSA as an eligible organization. The language is a result of the Balanced Budget Refinement Act of 1999. This language was adopted by the NAIC model regulation.

Section 89.790 (b)(6) (relating to the eligibility for benefits) adds the PACE program under section 1894 as an eligible program from which to disenroll within 12 months after the effective date. This language is based on the revised NAIC model regulation.

Fiscal Impact

The Insurance Department can review revised Medicare supplement filings in the course of normal business and anticipates that it will experience minimal or no increase in cost in its review.

The insurance industry will likely not incur additional costs associated with complying with the new federal requirements. The guaranteed eligibility provisions may increase the

utilization of services and therefore, the cost of policies. There is currently no way to assess these potential costs.

Effectiveness/Sunset Date

This order is effective upon publication in the *Pennsylvania Bulletin*. No sunset date has been assigned.

Paperwork

Adoption of these regulations should not require significant paperwork for insurance carriers' product development areas to implement the new federal changes.

Persons Regulated

This regulation applies to all insurance companies who issue Medicare supplement products in the Commonwealth.

Contact Person

Questions or comments regarding the final omitted rulemaking may be addressed to Peter J. Salvatore, Regulatory Coordinator, Pennsylvania Insurance Department, 1326 Strawberry Square, Harrisburg, Pennsylvania 17120, phone number (717) 787-4429. Questions and comments may also be e-mailed to psalvato@ins.state.pa.us or faxed to (717) 772-1969.

Regulatory Review

Under section 5(a) of the Regulatory Review Act, Act 24 of 1997, the agency submitted a copy of the regulations with the proposed rulemaking omitted on October 3, 2000 to the Independent Regulatory Review Commission (the Commission) and to the Chairpersons of the House Committee on Insurance and the Senate Committee on Banking and Insurance. On the same date, the regulations were submitted to the Office of Attorney General for review and approval under the Commonwealth Attorneys Act (71 P.S. §§ 732-101 - 732-506).

In accordance with section 5 (c) of the Regulatory Review Act, the regulations were deemed approved by the Senate Banking and Insurance Committee on _____, and deemed approved by the House Insurance Committee on _____. IRRC met on _____ and approved the regulations.

Findings

The Insurance Commissioner finds that:

(1) There is good cause to amend Chapter 89, Subchapter K, effective upon publication with the proposed rulemaking omitted. Deferral of the effective date of these regulations would

be impractical and not serve the public interest. Under section 204(3) (45 P.S. §1204(3)) of the CDL there is no purpose to be served by deferring the effective date. An immediate effective date will best serve the public interest by ensuring Pennsylvania's compliance with the new federal requirements and retention of enforcement authority over all aspects of Medicare supplement policies.

(2) There is good cause to forego public notice of the intention to amend Chapter 89, Subchapter K, because notice of the amendment under the circumstances is unnecessary and impractical for the following reasons:

(i) The changes mandated by federal law will go into effect with or without Pennsylvania regulatory action.

(ii) If the amendments are not implemented as established by the federal law, regulatory oversight of these requirements will be assumed by the federal government. If this were to occur it would split regulation of Medicare supplement policies between Pennsylvania and the federal government. Such dual regulation would negatively impact Pennsylvania consumers due to a shortage in federal enforcement staffing. Accordingly, it would be more difficult for Pennsylvania consumers to have complaints concerning the new requirements addressed by the federal government in a timely manner.

(iii) Public comment cannot change the fact that these federal requirements will be implemented by either Pennsylvania or the federal government). Nor can public comment have any impact upon the content of the new federal mandates.

Order

The Insurance Commissioner, acting under the authority in sections 206, 506, 1501 and 1502 of the Administrative Code of 1929, orders that:

(1) The Regulations of the Department at 31 Pa.Code, Chapter 89, Subchapter K, are amended as set forth in Annex A, with ellipses referring to the existing text of the regulations.

(2) The Department shall submit this order and Annex A to the Office of Attorney General and the Office of General Counsel for approval as to form and legality as required by law.

(3) The Department shall certify this order and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(4) This order shall take effect upon its publication in the *Pennsylvania Bulletin.*

M. Diane Koken
Insurance Commissioner

CONTINUATION SHEET FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU
Pursuant to Commonwealth Documents Law

ANNEX A

TITLE 31.—INSURANCE. PART IV.—LIFE INSURANCE. CHAPTER 89 - APPROVAL OF LIFE, ACCIDENT, AND HEALTH INSURANCE. Subchapter K. Medicare Supplement Insurance Minimum Standards

§89.772. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

* * * * *

Medicare + Choice plan -- A plan of coverage for health benefits under Medicare Part C as defined in section 1859 of the Social Security Act (42 U.S.C.A. § 1395w-28**(b)(1)) and includes**:

* * * * *

§89.776. Benefits standards for policies or certificates issued or delivered on or after July 30, 1992.

The following standards are applicable to Medicare supplement policies or certificates delivered or issued for delivery in this Commonwealth on or after July 30, 1992. A policy or certificate may not be advertised, solicited, delivered or issued for delivery in this Commonwealth as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(1) *General standards.* The following standards apply to Medicare supplement policies and certificates and are in addition to other requirements of this subchapter:

* * * * *

(vii) *Suspension by policyholder.*

* * * * *

(C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for a period 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 such loss and pays the premium attritutable to the period, effective as of the date of termination of entitlement.

([C]**D**) Reinstitution of these coverages:

* * * * *

(2) *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 shall also offer a policy or certificate to prospective insureds meeting the Plan B benefit plan. An issuer may make available to prospective insureds Medicare Supplement Insurance Benefit Plans C, D, E, F, G, H, I and J as listed in § 89.777(e) (relating to standard Medicare supplement benefit plans). The core packages are as follows:

* * * * *

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

(3) *Standards for additional benefits.* The following additional benefits shall be included in Medicare Supplement Benefit Plans B, C, D, E, F, G, H, I and J only as provided by § 89.777.

* * * * *

(ix) Preventive medical care benefit. 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 may not include payment for a procedure covered by Medicare. Coverage for the preventive health services is as follows:

* * * * *

(B) One or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(I) [Fecal occult blood test or digital] **Digital** rectal examination, [or both].

[(II) Mammogram].

([III] **II**) Dipstick urinalysis for hematuria, bacteriuria and proteinuria.

([IV] **III**) Pure tone (air only) hearing screening test, administered or

ordered by a physician.

([V] **IV**) Serum cholesterol screening every 5 years.

([VI] **V**) Thyroid function test.

([VII] **VI**) Diabetes screening.

(C) [Influenza vaccine administered at an appropriate time during the year and] Tetanus and Diphtheria booster every 10 years.

* * * * *

§89.783. Required disclosure provisions.

(a) *General rules.*

* * * * *

(6) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person eligible for Medicare, shall provide to these applicants a [Guide to Health Insurance for People with Medicare] ***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] ***Guide*** shall be made whether or not these policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this subchapter. Except in the case of direct response issuers, delivery of the [Guide] ***Guide*** shall be made to the applicant at the time of application and acknowledgment of receipt of the [Guide] ***Guide*** shall be obtained by the issuers. Direct response issuers shall deliver the [Guide] ***Guide*** to the applicant upon request but not later than at the time the policy is delivered.

* * * * *

(c) *Outline of coverage requirements for Medicare supplement policies.*

* * * * *

(5) The following items shall be included in the outline of coverage in the order prescribed in this paragraph:

* * * * *

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

* * * * *

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page:

Benefit Plans _____(insert letters of plans 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 & B.

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 (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	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled	Skilled	Skilled	Skilled		Skilled	Skilled	Skilled	Skilled	
	Part A	Part A	Part A	Part A	Part A		Part A	Part A	Part A	Part A	
		Part B			Part B					Part B	
					Part B Excess		Part B Excess		Part B Excess	Part B Excess	
		Foreign Travel	Foreign	Foreign	Foreign		Foreign	Foreign	Foreign	Foreign	
			At-Home				At-Home		At-Home	At-Home	
								Basic Drugs	Basic Drugs	Extended	
				Preventive						Preventive	

*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 one has paid a calendar year [$1500] $1530 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are [$1500] $1530. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does 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.

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			$[760] 776 (Part A deductible)
First 60 days	All but $[760] 776	$0	
61st thru 90th day	All but $[190] 194 a day	$[190] 194 a day	$0
91st day and after:			
--- While using 60 lifetime reserve days	All but $[380] 388 a day	$[380] 388 a day	$0
--- Once lifetime reserve days are used:		100% of Medicare	
---Additional 365 days	$0	eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $ [95] 97 a day	$0	Up to $ [95] 97 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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 a outpatient medical and surgical services a supplies, physical and speech therap diagnostic tests, durable medical equipme			
First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$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		$ [760] 776 (Part A deductible)	
First 60 days	All but $ [760] 776		
61st thru 90th day	All but $ [190] 194 a day	$ [190] 194 a day	$0
91st day and after:			$0
---While using 60 lifetime reserve days	All but $ [380] 388 a day	$ [380] 388 a day	
---Once lifetime reserve days are used:	$0	100% of Medicare eligible expenses	$0
---Additional 365 days			$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $ [95] 97 a day	$0	Up to $[95] 97 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient 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*	$0	$0	$100 (Part B deductible
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$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 $ [760] 776	$ [760] 776 (Part A deductible)	$0
61st thru 90th day	All but $ [190] 194 a day	$ [190] 194 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $ [380] 384 a day	$ [380] 384 a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $ [95] 97 a day	Up to $ [95] 97 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient 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 (Part B deductible)	$0
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$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 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 C (continued)

OTHER BENEFITS - COVERED BY MEDICARE

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

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days		$ [760] 776 (Part A deductible)	$0
61st thru 90th day	All but $[760] 776		
91st day and after:	All but $ [190] 194 a day	$ [190] 194 a day	$0
---While using 60 lifetime reserve days			
---Once lifetime reserve days are used:	All but $ [380] 388 a day	$ [380] 388 a day $0	$0
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $ [95] 97 a day	Up to $ [95] 97 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient 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 (Part B deductible)
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$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

(continued)

PLAN D (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment			
First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
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 - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 life-time 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		$ [760] 776 (Part A deductible)	$0
61st thru 90th day	All but $ [760] 776		
91st day and after:	All but $ [190] 194 a day	$ [190] 194 a day	$0
---While using 60 lifetime reserve days			
---Once lifetime reserve days are used:	All but $ [380] 388 a day	$ [380] 388 a day	$0
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $ [95] 97 a day	Up to $ [95] 97 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient 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*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$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

(continued)

PLAN E (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

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 one has paid a calendar year [$1500] **$1530 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1500] **$1530**. 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 [$1500] **$1530** DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [$1500] **$1530** DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies	All but $ [760] **776**	$ [760] [**776** (Part A deductible)	
First 60 days	All but $ [190] **194** a day	$ [190] **194** a day	$0
61st thru 90th day			$0
91st day and after:			
---While using 60 lifetime reserve days	All but $ [380] **388** a day	$ [380] [**388** a day	$0
---Once lifetime reserve days are used:		100% of Medicare eligible expenses	
---Additional 365 days	$0		$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $ [95] **97** a day	Up to $ [95] **97** a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN F or HIGH DEDUCTIBLE PLAN F (cont.)

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 one has paid a calendar year [$1500]$1530** deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1500] **$1530.** 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 [$1500] **$1530** DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [$1500] **$1530** 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 (Part B deductible	$0
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric service)	20% (50% outpatient psychiatric service)	$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	$100 (Part B deductible	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F (cont.)

PARTS A & B

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

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$1500] **$1530** DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [$1500] **$1530** DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $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		$ [760] 776 (Part A deductible)	$0
61st thru 90th day	All but $ [760] 776		
91st day and after:	All but $ [190] 194 a day	$ [190] 194 a day	$0
---While using 60 lifetime reserve days			
---Once lifetime reserve days are used:	All but $ [380] 388 a day	$ [380] 388 a day	$0
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $ [95] 97 a day	Up to $ [95] 97 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient 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*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$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

(continued)

PLAN G (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
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 - NOT COVERED BY MEDICARE

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

PLAN 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		$ [760] 776 (Part A deductible)	$0
61st thru 90th day	All but $ [760] 776		
91st day and after:	All but $ [190] 194 a day	$ [190] 194 a day	$0
---While using 60 lifetime reserve days			
---Once lifetime reserve days are used:	All but $ [380] 388 a day	$ [380] 388 a day	$0
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $ [95] 97 a day	Up to $ [95] 97 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient 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*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$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

(continued)

PLAN H (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

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		$ [760] 776 (Part A deductible)	$0
61st thru 90th day	All but $ [760] 776		
91st day and after:	All but $ [190] 194 a day	$ [190] 194 a day	$0
---While using 60 lifetime reserve days	All but $ [380] 388 a day	$ [380] 388 a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $ [95] 97 a day	Up to $ [95] 97 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient 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*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$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

(continued)

PLAN I (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
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 - NOT COVERED BY MEDICARE

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

PLAN I

OTHER BENEFITS - NOT COVERED BY MEDICARE (continued)

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

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 one has paid a calendar year [$1500] **$1530** deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [$1500] **$1530**. 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 [$1500] **$1530** DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [$1500] **$1530** DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies		$ [760] 776 (Part A deductible)	
First 60 days	All but $[760] 776		$0
61st thru 90th day	All but $ [190] 194 a day	$ [190] 194 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $ [380] 388 a day		
---Once lifetime reserve days are used:		$ [380] 388 a day	$0
---Additional 365 days	$0		
---Beyond the additional 365 days	$0	100% of Medicare eligible expenses	$0 All costs
		$0	
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $ [95] 97 a day	Up to $ [95] 97 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

(continued)

PLAN J or HIGH DEDUCTIBLE PLAN J (cont.)

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 one has paid a calendar year [$1500] **$1530] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [$1500] **$1530**. 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 [$1500] **$1530** DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [$1500] **$1530** 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 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%(50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$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	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN J or HIGH DEDUCTIBLE PLAN J (cont.)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First $100 of Medicare approved amounts* Remainder of Medicare approved Amounts	100% $0 80%	$0 $100 (Part B deductible) 20%	$0 $0 $0
HOME HEALTH CARE (continued) 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 ---Number of visits covered (must be received within 8 weeks of last Medicare approved visit) ---Calendar year maximum	$0 $0 $0	Actual charges to $40 a visit Up to the number of Medicare approved visits, not to exceed 7 each week $1,600	Balance

PLAN J or HIGH DEDUCTIBLE PLAN J (cont.)

PARTS A & B (continued)

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

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

§ 89.790. Guaranteed issue for eligible persons.

(a) *Guaranteed issue.*

(1) Eligible persons are those individuals described in subsection (b) who**, subject to subsection (b)(2)(vi)** apply to enroll under the policy not later than 63 days after the date of the termination of enrollment described in subsection (b), and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

* * * * *

(b) *Eligible persons.* An eligible person is an individual described in paragraphs (1) - (6):

* * * * *

(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**, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare+Choice plan**:

(i) [The organization's or plan's certification has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides] **The certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or**

(ii) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuance of such plan;

([ii] **iii**) 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 HHS 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 (42 U.S.C.A. § 1395w-21(g)(3)(B)) (when the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856 of the Social Security Act (42 U.S.C.A. § 1395w-26), or the plan is terminated for all individuals within a residence area).

([iii] **iv**) The individual demonstrates, in accordance with guidelines established by the HHS Secretary, that one of the following applies:

* * * * *

([iv] v) The individual meets other exceptional conditions the HHS Secretary may provide.

(vi) An individual described in (2) may elect to apply subsection (a) by substituting, for the date of termination of enrollment, the date on which the individual was notified by the Medicare+Choice organization of the impending termination or discontinuance of the Medicare+Choice plan it offers in the area in which the individual resides, but only if the individual disenrolls from the plan as a result of such notification.

(vii) In the case of an individual making the election in (vi), the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under Subsection A shall only become effective upon termination of coverage under the Medicare+Choice plan involved.

* * * * *

(5) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare + Choice organization under a Medicare + Choice plan under Part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare risk or cost), any similar organization operating under demonstration project authority, **any PACE program under section 1894 of the Social Security Act,** any organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan) or any Medicare Select policy and the subsequent enrollment under this paragraph is terminated by the enrollee during the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment under section 1851(e) of the Social Security Act).

(6) The individual, upon first becoming eligible for benefits under Part A and enrolled in Part B, if eligible, of Medicare, enrolls in a Medicare + Choice plan under Part C of Medicare, **or in a PACE program under section 1894,** and disenrolls from the plan **or program** within 12 months after the effective date of enrollment.

* * * * *

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
SPECIAL PROJECTS OFFICE
1326 Strawberry Square
Harrisburg, PA 17120

Phone: (717) 787-4429
Fax: (717) 772-1969
E-Mail: psalvato@ins.state.pa.us

October 3, 2000

Mr. Robert Nyce
Executive Director
Independent Regulatory Review Comm.
333 Market Street
Harrisburg, PA 17101

Re: Insurance Department Final-Omitted Regulation No. 11-205, Medicare Supplement Insurance Minimum Standards

Dear Mr. Nyce:

Pursuant to Section 5a(c) of the Regulatory Review Act, enclosed for your information and review is final-omitted regulation 31 Pa. Code, Chapter 89, Medicare Supplement Insurance Minimum Standards.

The changes, indicated to Chapter 89, are federally mandated under recent federal legislation, the Balanced Budget Refinement Act of 1999, and the Ticket to Work and Work Incentives Improvement Act. The federal law also establishes a timetable under which these changes are to be implemented by the states if they are to remain in compliance with the federal requirements and maintain regulatory authority in this area.

In order to comply with federal statutory minimum requirements for Medicare supplement policies, as mandated, the Insurance Commissioner finds that the proposed rulemaking procedures in Sections 201 and 202 of the CDL (45 P.S. §§1201 and 1202) are impracticable and unnecessary in this situation, and that the proposed rulemaking may be properly omitted under Section 204(3) of the CDL (45 P.S. §1204(3)).

If you have any questions regarding this matter, please contact me at (717) 787-4429.

Sincerely yours,

Peter J. Salvatore

Peter J. Salvatore
Regulatory Coordinator

11-205fo

TRANSMITTAL SHEET FOR REGULATIONS SUBJECT TO THE REGULATORY REVIEW ACT

RECEIVED

2000 OCT -3 PM 4: 18

REVIEW COMMISSION

I.D. NUMBER:	11-205
SUBJECT: Insurance	Medicare Supplement Insurance Standards - Approval of Life, Accident and Health
AGENCY:	DEPARTMENT OF INSURANCE #2152

TYPE OF REGULATION

Proposed Regulation

Final Regulation

X Final Regulation with Notice of Proposed Rulemaking Omitted

120-day Emergency Certification of the Attorney General

120-day Emergency Certification of the Governor

Delivery of Tolled Regulation
a. With Revisions b. Without Revisions

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
10-3-00	B. Stoplayer	HOUSE COMMITTEE ON INSURANCE
~~10-3-00~~		
10-3-00	Judy Petzel	SENATE COMMITTEE ON BANKING & INSURANCE
10/3/00	K.J. deBien	INDEPENDENT REGULATORY REVIEW COMMISSION
10/3/00	Jennifer M. Mann	ATTORNEY GENERAL
		LEGISLATIVE REFERENCE BUREAU

October 3, 2000