Regulatory Analysis Form

This space for use by IRRC

IRRC Number: 2292

(1) Agency

Insurance Department

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

11-212

(3) Short Title

Medicare Supplement Insurance Minimum Standards

(4) PA Code Cite

31 Pa. Code, Chapter 89 §§89.775, 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.
These amendments are necessary to maintain Pennsylvania's compliance with Federal requirements, which will ensure that Pennsylvania retains enforcement authority over Medicare Supplement policies. These standards were effective for Medicare Supplement issuers on December 21, 2000 under the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. The Federal legislation establishes that those states adopting the language of the NAIC Medicare Supplement model regulation with Federal revisions will be considered to be in compliance with the Federal requirements. Pennsylvania needs to adopt these revisions to the Medicare Supplement regulations by October 24, 2002 in order to avoid Federal intervention.

(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) provide the Insurance Commissioner with the authority and duty to promulgate regulations governing the enforcement of the laws relating to insurance. Other statutory factors are the federal statutory requirements of the Social Security Act (42 U.S.C. §1395ss) and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. No. 106-554).

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(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.

Yes. The amendments will bring the Department's regulations for the approval of Medicare supplement policies into compliance with the federal statutory requirements of the Social Security Act (42 U.S.C. §1395ss) and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. No. 106-554). This regulation needs to be in force prior to October 24, 2002 in order to prevent Federal intervention.

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

The Insurance Department seeks to amend 31 Pa. Code,Chapter 89, §§89.775, 89.776, 89.783, and 89.790 to be consistent with the authorizing statute and the Federal statute mentioned above. Moreover, it is in the public interest to amend the regulatory requirements in order to be consistent with other states and the Federal requirements for minimum standards.

(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.)

The public will benefit from the regulation to the extent that it will be consistent with the Federal statute.

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(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 as a result 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 issuing 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.

Comments regarding the amendment of this regulation were not solicited from the various trade associations representing the insurance industry. Comments from the various would not have altered the fact that the requirements found in the Federal statutes need to be followed by insurers issuing Medicare Supplement policies. These regulations allow Pennsylvania to maintain its jurisdictional oversight and does not in any way go against the Federal requirements.

(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 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.

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(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.

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(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.

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(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 31 Pa. Code, Chapter 89 §§89.775, 89.776, 89.783, and 89.790 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.

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(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.

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(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 general public then would be required by Federal statute.

(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 take effect upon approval of the final form regulation by the legislative standing committees, the Office of the Attorney General, and the Independent Regulatory Review Commission 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)

2292

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: [signature]
____________ Date of Approval	DOCUMENT/FISCAL NOTE NO. 11-212	9/11/02 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: [signature] M. Diane Koken Insurance Commissioner TITLE: ____________ (EXECUTIVE OFFICER, CHAIRMAN OR SECRETARY)	✈ Check if applicable. No Attorney General approval or objection within 30 days after submission.

NOTICE OF FINAL-OMITTED RULEMAKING

INSURANCE DEPARTMENT

31 Pa. Code, Chapter 89, Subchapter K,
§§89.775, 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, §§89.775, 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. The amendments will also bring the Department's regulations for the approval of Medicare supplement policies into compliance with the federal statutory requirements of the Social Security Act (42 U.S.C. §1395ss) and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. No. 106-554).

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)). Under 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.

The changes indicated to Subchapter K are federally mandated under recent federal legislation, specifically the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 that was effective December 21, 2000. Federal law requires that these changes be implemented by the states if they are to remain in compliance with the federal requirements and maintain regulatory authority in this area. The revised NAIC Medicare Supplement model regulation was adopted October 24, 2001 and the Department's new regulations must be adopted within one year following the NAIC adoption of the model regulations in order for Pennsylvania to retain regulatory authority in this area. In order to comply with federal statutory minimum requirements for Medicare supplement policies, as mandated by Sections 111 and 618 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, 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)).

Purpose

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 Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

These amendments are necessary to maintain Pennsylvania's compliance with federal requirements, which will ensure that Pennsylvania retains enforcement authority over Medicare Supplement policies and these new requirements. These standards were effective for Medicare Supplement issuers on December 21, 2000 under the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. The federal legislation establishes that states that adopt the language of the NAIC Medicare Supplement model regulation that has been revised to address the federal changes will be considered to be in compliance with the federal requirements. Pennsylvania needs to adopt these revisions to the Medicare Supplement regulations by October 24, 2002 in order to avoid federal intervention.

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

Explanation of Regulatory Requirements

Section 89.775(2)(vi) (relating to minimum benefit standards) has been modified to reflect the revised cost sharing structure requirements for hospital outpatient department services. The added language is based on the revised NAIC Medicare Supplement model regulation.

Section 89.776(1) (relating to benefit standards) has been modified. Section 89.776(1)(vii)(C) has been revised to reflect the federal requirements 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 NAIC Medicare Supplement model regulation.

Section 89.776(1) (relating to benefit standards) has been modified. Section 89.776(1)(vii)(D) has been revised to clarify that the reinstitution of Medicare Supplement coverage is applicable specifically to subparagraphs (b) and (c) of this subsection. 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 89.783(c) (relating to the required outline of coverage disclosure) has been amended to delete the specific outlines of coverage disclosure for Plans A through Plan J. These outlines of coverage contain information on the specific benefits that must be provided under each standardized Medicare Supplement policy. The inclusion of these outlines of coverage is not required by the NAIC Medicare Supplement model regulation. The outlines of coverage include deductibles and subscriber cost sharing amounts that change every year based on changes in the Medicare program cost sharing requirements.

It is impracticable to continue to change these outlines of coverage every year via regulation. The Department will instead maintain these outlines of coverage in written and electronic form that will be available on request to assure that Medicare Supplement issuers and subscribers have access to the most up-to-date information and coverage requirements. The Department will also incorporate the chart (Plans A-J) into the Department's website to provide consumers and insurers with easier access to the plans. This will allow both consumers and insurers access to the plans 24 hours a day, 7 days a week and not just when the Department is open for business. Furthermore, the Department will publish notice, in the *Pennsylvania Bulletin,* of the availability of the amended outlines when such revisions are made available to the Department by the United States Department of Health and Human Services.

Section 89.790(a)(1) (relating to guaranteed issue for eligible persons) has been revised to change the definition of an eligible person for guaranteed issue rights under the regulation. The new language is based on the revised NAIC Medicare Supplement model regulation.

Section 89.790(b)(2)(i) (relating to guaranteed issue for eligible persons) has been revised to clarify the permitted discontinuation of an individual's enrollment in a Medicare+Choice plan. The modified language is a result of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. This language is based on the revised NAIC model regulation.

Section 89.790(b)(2)(ii) (relating to guaranteed issue for eligible persons) has been revised to clarify the permitted discontinuation of an individual's enrollment in a Medicare+Choice plan. The modified language is a result of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. This language is based on the revised NAIC model regulation.

Section 89.790(b)(2)(vi) (relating to guaranteed issue for eligible persons) has been deleted to conform the regulation to new eligibility periods for Medicare+Choice enrollees created by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. This language is based on the revised NAIC model regulation.

Section 89.790(b)(2)(vii) (relating to guaranteed issue for eligible persons) has been deleted to conform the regulation to new eligibility periods for Medicare+Choice enrollees created by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. This language is based on the revised NAIC model regulation.

Section 89.790(b)(3)(i) has been modified to remove the reference to Medicare risk contracts under section 1876 of the Social Security Act (SSA) as required by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. This language is based on the revised NAIC model regulation.

Section 89.790(b)(5) (relating to termination of enrollment) has been modified to conform to changes in the SSA as a result of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. This language was adopted by the NAIC model regulation.

Section 89.790(b)(6) (relating to the eligibility for benefits) has been modified to conform to changes in the SSA as a result of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. This language is based on the revised NAIC model regulation.

Section 89.790(c) (relating to guaranteed issue time periods) has been added to set forth the guaranteed issue time periods for individuals required by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. This language was adopted by the NAIC model regulation.

Section 89.790(d) (relating to extended Medigap access for interrupted trial periods) has been added to define the enrollment periods for individuals whose enrollment in a Medicare+Choice plan is interrupted within the first twelve (12) months of enrollment. This section is necessary to meet requirements set by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. This language was adopted in 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

The person to contact for information on the amendment of these regulations is Peter J. Salvatore, Regulatory Coordinator, 1326 Strawberry Square, Harrisburg, Pennsylvania 17120, telephone number (717) 787-4429. Inquiries regarding this final-omitted rulemaking can also be made to psalvatore@state.pa.us or faxed to (717) 772-1969.

Regulatory Review

Under Section 5a(c) of the Regulatory Review Act, Act 24 of 1997, the agency submitted a copy of the regulations with the proposed rulemaking omitted on September 13, 2002 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).

On October 2, 2002, the Department requested a tolling of the regulation in order to clarify the regulation. The IRRC did not object to the tolling. On October 10, 2002, the Department resubmitted the regulation to the IRRC and the Chairpersons of the House Committee on Insurance and the Senate Committee on Banking and Insurance. On the same date, the regulations were resubmitted 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) 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 (45 P.S. §1204(3)) 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; and

(iii) Public comment cannot change the fact that these federal requirements will be implemented (either by 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

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

§ 89.775. Minimum benefit standards for policies or certificates issued for delivery prior to July 30, 1992.

A policy or certificate may not be advertised, solicited or issued for delivery in this Commonwealth as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are consistent with this subchapter.

* * * * *

(2) *Minimum benefit standards.* The following represent minimum benefit standards:

* * * * *

(vi) 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 a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible.

* * * * *

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

The following standards apply 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 at the request of the policyholder if the policyholder is entitled to benefits under [s] Section 226(b) of the Social Security Act (42 U.S.C.A. § 426(b)) and is covered under a group health plan (as defined in section 1862 (b)(1)(A)(v) of the Social Security Act (42 U.S.C.A. § 1395y (b)(ii)(A)(v)). If suspension occurs 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 [attritutable] <u>attributable</u> to the period, effective as of the date of termination of [entitlement] <u>enrollment in the group health plan</u>.

(D) Reinstitution of these coverages <u>as described in clauses (B) and (C)</u>:

* * * * *

(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 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.

* * * * *

§ 89.783. Required disclosure provisions.

* * * * *

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

* * * * *

(6) The cover page and the accompanying charts for Plan A to Plan J of the Outlines of Coverage are available upon request from the Department in printed and electronic formats. In addition, notice will be published, in the *Pennsylvania Bulletin*, of the availability of the amended outlines when such revisions are made available to the Department by the United States Department of Health and Human Services as published in the Federal Register. The Outlines of Coverages will be made available on the Department's website at http://www.insurance.state.pa.us.

[[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	G	H	I	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 one has paid a calendar year $1580 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are $1580. 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			
First 60 days	All but $792	$0	$792 (Part A deductible)
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after:			
--- While using 60 lifetime reserve days	All but $396 a day	$396 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 $99 a day	$0	Up to $99 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 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 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 $792	$792 (Part A deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $396 a day	$396 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 $99 a day	$0	Up to $99 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 $792	$792 (Part A deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $396 a day	$396 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 $99 a day	Up to $99 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		$792 (Part A	
61st thru 90th day	All but $792	deductible)	$0
91st day and after:	All but $198 a day	$198 a day	$0
---While using 60 lifetime reserve days			
---Once lifetime reserve days are used:	All but $396 a day	$396 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 $99 a day	Up to $99 a day	$0
		$0	
101st day and after	$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

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 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		$792 (Part A	
61st thru 90th day	All but $792	deductible)	$0
91st day and after:	All but $198 a day	$198 a day	$0
---While using 60 lifetime reserve days			
---Once lifetime reserve days are used:	All but $396 a day	$396 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 $99 a day	Up to $99 a day	$0
		$0	
101st day and after	$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

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

(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 $1580 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $1580. 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 $1580 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1580 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $ 396 a day	$396 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 $99 a day	Up to $99 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	All but very limited	$0	Balance

you are terminally ill and you elect to receive these services	coinsurance for out-patient drugs and inpatient respite care		

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 $1580 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $1580. 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 $1580 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1580 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	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

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1580 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1580 DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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 $792	$792 (Part A deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after: ---While using 60 lifetime reserve days	All but $396 a day	$396 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 $99 a day	Up to $99 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

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 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 $792	$792 (Part A deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after: ---While using 60 lifetime reserve days	All but $396 a day	$396 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 $99 a day	Up to $99 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	All but $792	$792 (Part A deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $396 a day	$396 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 $99 a day	Up to $99 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 $1580 deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are $1580. 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 $1580 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1580 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $396 a day	$396 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 $99 a day	Up to $99 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 $1580 deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are $1580. 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 $1580 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $1580 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	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
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	$0		Balance
---Benefit for each visit		Actual charges to $40 a visit	
---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	

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 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
EXTENDED OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE First $250 each calendar year Next $6,000 each calendar year Over $6,000 each calendar year	 $0 $0 $0	 $0 50%—$3,000 calendar year maximum benefit $0	 $250 50% 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 Additional charges	 $0 $0	 $120 $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),] seek to enroll under the policy during the period specified in subsection c, and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer may not:

(i) Deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection ([c]e) that is offered and is available for issuance to new enrollees by the issuer.

* * * * *

(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 (42 U.S.C.A. § 1395eee), and there are circumstances similar to those described as follows that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare+Choice plan:

(i) 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 the certification.]

(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 the plan.]

* * * * *

[(vi) An individual described in paragraph (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 the notification.

(vii) In the case of an individual making the election in subparagraph (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.]

(3) The individual's enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) and the individual is enrolled with one of the following:

(i) An eligible organization under a contract under section 1876 of the Social Security Act (42 U.S.C.A. § 1395mm) (Medicare [risk or]cost).

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

(iii) An organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (42 U.S.C.A. § 1395l(a)(1)(A)) (health care prepayment plan).

(iv) An organization under a Medicare Select policy.

* * * * *

(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) (42 U.S.C.A. § 1395mm), any similar organization operating under demonstration project authority, any PACE [program] provider 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] with a PACE [program] provider under section 1894 of the Social Security Act, and disenrolls from the plan or program within 12 months after the effective date of enrollment.

(c) Guaranteed Issue Time Periods

(1) In the case of an individual described in subsection (b)(1), the guaranteed issue period 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 such a termination or cessation) and ends sixty-three (63) days after the date of the applicable notice;

(2) In the case of an individual described in subsection (b)(2), (b)(3), (b)(5) or (b)(6) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the

individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;

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

(4) In the case of an individual described in section (b)(2), (b)(4)(ii), (b)(4)(iii), (b)(5) or (b)(6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date; and

(5) In the case of an individual described in subsection (b) but not described in the proceeding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date

(d) Extended medigap access for interrupted trial periods

(1) In the case of an individual described in subsection (b)(5) (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in subsection (b)(5) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in section 89.790 (b)(5)

(2) In the case of an individual described in subsection (b)(6) (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in subsection (b)(6) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an

intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in section 89.790 (b)(6); and

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

[(c)] (e) *Products to which eligible persons are entitled.* The Medicare supplement policy to which eligible persons are entitled under:

* * * * *

[(d)] (f) *Notification provisions.*

* * * * *

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

Phone: (717) 787-4429
Fax: (717) 772-1969
E-mail: psalvatore@state.pa.us

October 10, 2002

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

RE: RESUBMISSION OF PREVIOUSLY TOLLED FINAL-OMITTED RULES INSURANCE DEPARTMENT
Regulation #11-212
31 Pa. Code, Chapter 89, Medicare Supplement Insurance Minimum Standards

Dear Mr. Nyce:

By letter dated October 2, 2002, the Independent Regulatory Review Commission (IRRC) identified some clarification issues with respect to the above-referenced final-omitted rules, specifically §89.783(c)(6), 89.790(d)(1) and (d)(3) and suggested that the issues could be clarified through the tolling procedure found in 1 Pa. Code, §305.7 (relating to procedures for tolling).

On October 2, 2002, the Pennsylvania Insurance Department requested a tolling of the regulation. The Department is now resubmitting the regulation for your review. The issues raised by IRRC and corrected by the Department are as follows:

1. Section 89.783(c)(6) (on page 3) explains how the required charts for Plans A to J can be obtained and outlines how the public will be notified when the charts are amended. However, the section should refer to the source for the charts. This could include a specific reference to the pertinent federal law or regulation. The Department added reference to the Department of Health and Human Services.

2. The Department has made the correction § 89.783(c)(6) (on page 3) to read "... will be made available on the Department's website at http://www.insurance.state.pa.us."

3. The Department has corrected § 89.790(d)(1) (on page 39) to read "...involuntarily terminated with**in** the first twelve (12) months...."

4. The Department has corrected § 89.790(d)(3) (on page 40), to read "...beginning on the date on which the individual first **enrolled** with such an organization, provider, plan or program."

The Department is resubmitting the previously tolled regulation and anticipates it being heard at the October 24, 2002 IRRC meeting.

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

Sincerely yours,

Peter J. Salvatore
Regulatory Coordinator

TRANSMITTAL SHEET FOR REGULATIONS SUBJECT TO THE REGULATORY REVIEW ACT

I.D. NUMBER: 11-212

SUBJECT: Medicare Supplement Insurance Minimum Standards

AGENCY: DEPARTMENT OF INSURANCE

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. _X___ With Revisions b. _____ Without Revisions

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
10-10-02	[signature]	HOUSE COMMITTEE ON INSURANCE
10-10-02	M E Mitchell	
10/10/02	D. Herman	SENATE COMMITTEE ON BANKING & INSURANCE
10/10/02	J. McDaniel	
10/10/02	Elena Pagan	INDEPENDENT REGULATORY REVIEW COMMISSION
10-9	Pam Seibold	ATTORNEY GENERAL
_____	____________	LEGISLATIVE REFERENCE BUREAU

October 4, 2002