

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 61st thru 90th day 91st day and after: ---While using 60 lifetime reserve days ---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	All but \$[776] All but \$[194] a day All but \$[388] a day \$0 \$0	\$[776] (Part A deductible) \$[194] a day \$[388] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21st thru 100th day 101st day and after	All approved amounts All but \$[96] a day \$0	\$0 Up to \$[96] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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

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

PLAN 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	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN I

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 maxi- mum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
BASIC OUTPATIENT PRE- SCRIPTION 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 [\$1530] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [\$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 \$1530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$1530 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: ---While using 60 lifetime reserve days ---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	All but \$[776] All but \$[194] a day All but \$[388] a day \$0 \$0	\$[776] (Part A deductible) \$[194] a day \$[388] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21st thru 100th day 101st day and after	All approved amounts All but \$[96] a day \$0	\$0 Up to \$[96] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

(continued)

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

PLAN J or HIGH DEDUCTIBLE PLAN J

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

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

**This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [\$1530] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [\$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 \$1530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$1530 DEDUCTIBLE,** YOU PAY
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
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* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$100 (Part B deductible) Generally 20% 100%	\$0 \$0 \$0
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$100 (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$1530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$1530 DEDUCTIBLE,** YOU PAY
<p>HOME HEALTH CARE MEDICARE APPROVED SERVICES</p> <ul style="list-style-type: none"> —Medically necessary skilled care services and medical supplies —Durable medical equipment 	<p>100%</p>	<p>\$0</p>	<p>\$0</p>
<ul style="list-style-type: none"> First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts 	<p>\$0</p> <p>80%</p>	<p>\$100 (Part B deductible)</p> <p>20%</p>	<p>\$0</p> <p>\$0</p>
<p>HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE</p> <p>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</p> <ul style="list-style-type: none"> —Benefit for each visit —Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit) —Calendar year maximum 	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>Actual charges to \$40 a visit</p> <p>Up to the number of Medicare Approved visits, not to exceed 7 each week</p> <p>\$1,600</p>	<p>Balance</p>

(continued)

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$1530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$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
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.

- 2221 REQUIRED DISCLOSURE PROVISIONS - NOTICE REGARDING POLICIES OR CERTIFICATES WHICH ARE NOT MEDICARE SUPPLEMENT POLICIES**
- 2221.1 Any accident and sickness insurance policy or certificate other than a Medicare supplement policy, any policy issued pursuant to a contract under section 1876 of the Social Security Act, any disability income policy; or any other policy identified in subsection 2202.2, that is issued for delivery in the District to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate.
- 2221.2 The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds and the notice shall be in no less than twelve (12) point type and shall contain the following language:
- “THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM THE COMPANY.”**
- 2221.3 Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subsection 2221.1 shall disclose using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with the application for the policy or certificate.
- 2222 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE**
- 2222.1 Application forms shall include the following statements and questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force.
- 2222.2 A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.
- (a) Required Statements.
- (1) You do not need more than one Medicare supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage;
 - (2) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy;
 - (3) The benefits and premiums under the Medicare supplement policy can be suspended if requested during your entitlement to benefits under Medicaid for twenty-four (24) months. You must request this suspension within ninety (90) days of becoming eligible for

Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within ninety (90) days of losing Medicaid eligibility.

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

(b) Required Questions. To the best of your knowledge:

- (1) Do you have another Medicare supplement policy or certificate in force?

If so, with which company?

- (2) Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

(A) If so, with which company?

(B) What kind of policy?

- (3) Are you covered for medical assistance through the District's Medicaid program?

(A) As a Specified Low Income Medicare Beneficiary (SLMB)?

(B) As a Qualified Medicare Beneficiary (QMB)?

(C) For other Medicaid medical benefits?

2222.3 Agents shall list any other health insurance policies they have sold to the applicant as follows:

- (a) Policies sold which are still in force; and
- (b) Policies sold in the past five (5) years which are no longer in force.

2222.4 In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

2222.5 Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage;

- (a) One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer; and
- (b) A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

2222.6 The notice required by subsection 2222.5 for an issuer shall be provided in substantially the following form in no less than twelve (12) point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

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

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If after due consideration, you find that purchase of Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

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

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

- _____ Additional benefits.
- _____ No change in benefits, but lower premiums.
- _____ Fewer benefits and lower premiums.
- _____ Other (please specify)_____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. District of Columbia law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.] Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

(Signature of Agent, Broker or Other Representative)*

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

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

- 2222.7 Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

2223 FILING REQUIREMENTS FOR ADVERTISING

- 2223.1 An issuer shall provide a copy of any Medicare supplement advertisement intended for use in the District of Columbia, whether through written, radio or television media to the Commissioner for review or approval by the Commissioner to the extent it may be required under the laws of the District of Columbia.

2224 STANDARDS FOR MARKETING

- 2224.1 An issuer, directly or through its producers, shall:

- (a) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate;
- (b) Establish marketing procedures to assure excessive insurance is not sold or issued;
- (c) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

“Notice to buyer: This policy may not cover all of your medical expenses.”

- (d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance; and
- (e) Establish audit procedures for verifying compliance with this subsection.

2224.2 The following acts and practices are prohibited:

- (a) “Twisting,” which means knowingly making or misleading eading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.
- (b) “High pressure tactics,” which means employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
- (c) “Cold lead advertising,” which means making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

2224.3 The terms “Medicare Supplement,” “Medigap,” “Medicare Wrap-Around” and words of similar import shall not be used unless the policy is issued in compliance with this chapter.

2225 APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE

2225.1 In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

2225.2 Any sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

2226 REPORTING OF MULTIPLE POLICIES

2226.1 On or before March 1 of each year, an issuer shall report the following information for every individual resident of the District of Columbia for which the issuer has in force more than one Medicare supplement policy or certificate:

(a) Policy and certificate number; and

(b) Date of issuance.

2226.2 The items set forth above must be grouped by individual policyholder.

2226.3 Appendix B contains a reporting form for compliance with this section.

2227 PROHIBITION AGAINST PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES

2227.1 If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy.

2227.2 If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits its similar to those contained in the original policy or certificate.

2228 SEVERABILITY

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

2299 DEFINITIONS

2299.1 For purposes of this chapter, the words and phrases set forth in this section shall have the meanings ascribed.

Applicant - means:

(a) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

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

Bankruptcy - means a Medicare+Choice organization which is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the District.

Certificate - means any certificate delivered or issued for delivery in the District of Columbia under a group Medicare supplement policy.

Certificate form - means the form on which the certificate is delivered or issued for delivery by the issuer.

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

Creditable coverage - means with respect to an individual, coverage of the individual provided under any of the following:

- (a) A group health plan;
- (b) Health insurance coverage;
- (c) Part A or Part B of Title XVII of the Social Security Act (Medicare);
- (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;
- (e) Chapter 55 of Title 10 of the United States Code (CHAMPUS);
- (f) A medical care program of the Indian Health Service or of a tribal organization;
- (g) A District health benefits risk pool;
- (h) A health plan offered under chapter 89 of Title 5 of the United States Code (Federal Employees Health Benefits Program);
- (i) A public health plan as defined in federal regulation; and
- (j) A health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e).

Creditable coverage - means insurance coverage that does not include one or more, or any combination of, the following:

- (a) Coverage only for accident or disability income insurance, or any combination thereof;
- (b) Coverage issued as a supplement to liability insurance;
- (c) Liability insurance, including general liability insurance and automobile liability insurance;

- (d) Workers' compensation or similar insurance;
- (e) Automobile medical payment insurance;
- (f) Credit-only insurance;
- (g) Coverage for on-site medical clinics; and
- (h) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

Creditable coverage - means insurance coverage that does not include the following if it is offered as a separate policy, certificate or contract of insurance:

- (a) Medicare supplemental health insurance as defined under section 1882 (g) (1) of the Social Security Act;
- (b) Coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and
- (c) Similar supplemental coverage provided to coverage under a group health plan.

District - means the District of Columbia.

Employer welfare benefit plan - means a plan, fund or program of employee benefits as defined in the Employee Retirement Income Security Act, 29 U.S.C. § 1002.

Insolvency - means an issuer, licensed to transact the business of insurance in the District, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

Issuer - means an insurance company, fraternal benefit society, health care service plan, health maintenance organization, and any other entity delivering or issuing, for delivery in the District of Columbia, Medicare supplement policies or certificates.

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

Medicare+Choice plan - means a plan of coverage for health benefits under Medicare Part C as defined in section 1859 of Title IV of Public L. No. 105-33, and includes:

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

- (2) Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and
- (3) Medicare+Choice private fee-for-service plans.

Medicare supplement policy - means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical services associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the Social Security Act or an issued policy under a demonstration project specified in 42 U.S.C. §1395ss(g) (1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

Policy form - means the form on which the policy is delivered or issued for delivery by the issuer.

Secretary - means the Secretary of the United States Department of Health and Human Services.

APPENDIX A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing Exhibit _____
 Title _____ Telephone Number _____

Line		(a) Earned Premium ³	(b) Incurred Claims ⁴
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues ⁵		
	c. Net (for reporting purposes = 1a-1b)		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		
4.	Refunds Last Year (Excluding Interest)		
5.	Previous Since Inception (Excluding Interest)		
6.	Refunds Since Inception (Excluding Interest)		
7.	Benchmark Ratio Since Inception (<i>see worksheet for Ratio 1</i>)		
8.	Experienced Ratio Since Inception (<i>Ratio 2</i>) $\frac{\text{Total Actual Incurred Claims (line 3, col. b)}}{\text{Total Earned Prem. (line 3, col. a) - Refunds Since Inception (line 6)}}$		
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10.	Tolerance Permitted (obtained from credibility table)		

Medicare Supplement Credibility Table

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

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

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

3 Includes Modal Loadings and Fees Charged

4 Excludes Active Life Reserves

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

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

TYPE¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing Exhibit _____
 Title _____ Telephone Number _____

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

12.	Adjusted Incurred Claims [Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6)] x Ratio 3 (line 11)	
13.	Refund = Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6) –[Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1)]	

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

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

Signature

Name - Please Type

Title - Please Type

Date

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

TYPE¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing Exhibit _____
 Title _____ Telephone Number _____

5952

(a) ³	(b) ⁴	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) ⁵
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89

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

TYPE¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing Exhibit _____
 Title _____ Telephone Number _____

5953

(a) ³	(b) ⁴	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) ⁵
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77

APPENDIX B

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

Phone Number: _____

Due March 1, annually

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

Policy and Certificate #	Date of Issuance

Signature

Name and Title (please type)

Date

APPENDIX C

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

1. Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- other approved items and services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that provide benefits for specified limited services.]

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

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

- hospitalization
- physician services
- other approved items and services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

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

This is not Medicare Supplement Insurance

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

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

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

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice care
- other approved items & services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

<p style="text-align: center;">IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</p>
--

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

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

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

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- other approved items and services

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

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

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

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

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

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

- hospitalization
- physician services
- other approved items and services

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

Before You Buy This Insurance

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- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

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

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

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- other approved items and services

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

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- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

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

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

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

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

- hospitalization
- physician services
- hospice
- other approved items and services

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

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

<p style="text-align: center;">IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</p>

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

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- other approved items and services

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

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

<p style="text-align: center;">IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</p>

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

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice care
- other approved items & services

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

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

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

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

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- other approved items and services

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

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

**DISTRICT OF COLUMBIA DEPARTMENT OF INSURANCE
AND SECURITIES REGULATION**

NOTICE OF FINAL RULEMAKING

The Commissioner of the Department of Insurance and Securities Regulation, pursuant to the authority set forth in section 10 of the Public Insurance Adjuster Licensure Act of 2002, effective March 27, 2003 (D.C. Law 14-256; D.C. Official Code § 31-1631.09) (“Act”), gives notice of the adoption of the following emergency rules to be included in Title 26, Chapter 39 of the District of Columbia Municipal Regulation (“DCMR”). The rules were adopted on an emergency basis to preserve the health, safety, and welfare of District citizens through the effective regulation of public insurance adjusters as required by the Act. The rules establish a licensing process for initial and renewal applications for public insurance adjusters, requires public insurance adjusters to pass a licensing examination, requires public insurance adjusters to hold client funds in an escrow or trust account, establishes record keeping requirements, subjects public insurance adjusters to disciplinary action, including civil penalties for certain prohibited practices, requires public insurance adjusters to make disclosures, and requires public insurance adjusters to use specified language in their contracts with insureds.

A notice of emergency and proposed rules was published in the D.C. Register on April 25, 2003 (50 DCR 3191). No comments on the proposed rules were received. No substantive changes have been made. These rules shall become effective on the date of publication of this notice in the D.C. Register.

Title 26 is amended to add a new Chapter 39 to read as follows:

CHAPTER 39 - LICENSURE AS A PUBLIC INSURANCE ADJUSTER**3900 GENERAL PROVISIONS**

- 3900.1 No person shall act as or hold himself out as a public insurance adjuster unless the person has been issued a license in accordance with these rules.
- 3900.2 An applicant for licensure as a public insurance adjuster shall submit a properly completed application.
- 3900.3 An applicant who is licensed as a public insurance adjuster in another jurisdiction shall submit a properly completed application accompanied by a certificate of good standing from the insurance licensing authority of the applicant’s home state that indicates that the applicant holds a valid public adjuster insurance license issued by that state.

- 3900.4 A natural person acting as a public insurance adjuster in the District through a business entity shall also obtain a public insurance adjuster license for the business entity. For purposes of this section, a "business entity" includes any corporation, partnership, limited partnership, joint venture, association, exchange, or limited liability company, limited liability partnership, or other enterprise. A business entity applying for a license as a public insurance adjuster shall submit proof that:
- (a) The business entity is, or will become as soon as practicable, lawfully registered with the Department of Consumer and Regulatory Affairs to do business in the District; and
 - (b) Every officer, director, shareholder, general partner, or member of the limited liability company, or partnership, who personally engages in business of public insurance adjusting in the District, as defined in D.C. Official Code § 31-1631.01(5), is individually licensed as a public insurance adjuster pursuant to these rules.
- 3900.5 Every public insurance adjuster shall maintain a bond executed by the public insurance adjuster as principal and a surety company authorized to do business in the District, in the principal sum of \$20,000, for the benefit of any person who suffers a loss as a result of fraud or dishonesty on the part of the public insurance adjuster.
- 3900.6 Notwithstanding the information requested in the application, as required in subsection 3900.2, an applicant shall also disclose the full name and residence address of each person who directly or indirectly owns, controls, holds with power to vote, or holds proxies representing, ten percent or more of the voting securities of the licensee.
- 3900.7 The Commissioner may, in addition to other grounds set forth in these rules, deny an application or suspend or revoke the license of a public insurance adjuster if any person who directly or indirectly owns, controls, holds with power to vote, or holds proxies representing ten percent or more of the voting securities of the public insurance adjuster, does not meet the qualifications for licensure set forth in these rules.
- 3900.8 Every applicant for an initial or renewal public insurance adjuster license shall file with such application a list of the full names of all employees who are authorized to negotiate claim settlements, and every licensee shall inform the Commissioner in writing within 30 days from the date of the occurrence of the name of any employee hired or terminated subsequent to the filing of the initial list.
- 3900.9 Any license issued pursuant to these rules shall at all times be the property of the government of the District and upon any suspension, revocation, nonrenewal, expiration or other termination shall no longer be in force and effect.

(a) Upon any suspension, revocation or other termination of a license, the licensee or any other person having custody of the license shall immediately deliver it to the Commissioner by personal delivery or by registered or certified mail.

(b) Where a license is lost, stolen or destroyed, the Commissioner may accept in lieu of the return of the license, an affidavit of the licensee or other person responsible for the license, setting forth the facts which prevent the return of the license.

(c) Failure to pay any requested fee for any reason including, but not limited to, a check being dishonored, shall render a license null and void.

(d) A license which was voluntarily cancelled by a licensee may be reinstated for the balance of the license term upon written request of the licensee and payment of the processing fee.

3900.10 The Commissioner may grant a temporary public insurance adjuster license before the applicant has passed the licensing examination required in § 3901.1, provided the applicant is otherwise qualified for licensure as a public insurance adjuster. The temporary license shall expire on September 30, 2003.

3901 LICENSING EXAMINATION

3901.1 Except as provided in § 3900.10, no person shall act as a public insurance adjuster in the District unless that person has taken and passed a licensing examination, which may be administered by the Department or by a vendor under contract to the Department.

3901.2 Examinations shall be administered at such times and places as may be designated by the Commissioner. If a contract vendor is utilized it shall provide the Commissioner with at least 60 days prior notice of the dates and times of the scheduled examinations.

3901.3 The Commissioner shall have the sole responsibility for establishing minimum qualification and passing requirements for candidates taking the licensing examination. The qualification and passing requirements shall be on file at the offices of the Department and shall be made available for public inspection.

3902 RENEWAL OF LICENSES

3902.1 A license issued pursuant to these rules shall expire on April 30th of each odd numbered year.

- 3902.2 At least thirty (30) days prior to the expiration of a license the Commissioner shall send an application for renewal by first class mail to the license holder at the address of the license holder on file with the Commissioner.
- 3902.3 The license holder shall notify the Commissioner in writing of any change of home or business address within thirty (30) days of the change of address.
- 3902.4 The failure of the license holder to receive the notice required under subsection 3902.2 does not relieve the license holder of the responsibility for renewing the license.
- 3902.5 A public insurance adjuster who fails to renew a license prior to the expiration date may renew the license within thirty (30) days after expiration upon paying the required late fee. Upon renewal, the public insurance adjuster shall be deemed to have possessed a valid license during the period between the expiration of the license and the renewal thereof.
- 3902.6 If a public insurance adjuster fails to renew a license within thirty (30) days after expiration of the license, the license shall be considered to have lapsed on the date of expiration, and the license holder shall be required to apply for reinstatement pursuant to section 3903.

3903 REINSTATEMENT OF AN EXPIRED LICENSE

- 3903.1 This section shall apply to an applicant for reinstatement of an expired license issued under these rules.
- 3903.2 An applicant for reinstatement under this section shall file an application with the Department on the prescribed form and shall pay the required reinstatement fee.
- 3903.3 An applicant for reinstatement under this section shall demonstrate fitness to resume practice by submitting evidence satisfactory to the Commissioner that the applicant has the competency and knowledge of District law necessary to resume transacting business as a public insurance adjuster and that such resumption will not be detrimental to the public interest or the integrity of the insurance adjusting profession.
- 3903.4 In making a determination pursuant to subsection 3903.3, the Commissioner shall consider the following:
- (a) The length of time that the applicant has transacted insurance business as a public insurance adjuster in the District or in another state;
 - (b) The length of time after expiration of the applicant's license that

the applicant was not transacting business as a public insurance adjuster, either in the District or in another state;

(c) The violation of any laws by the applicant;

(d) The applicant's present character; and

(e) The applicant's present qualifications and competency to transact insurance business.

3903.5 The Commissioner may require an applicant to complete certain educational or training requirements, or to pass the public insurance adjuster examination, prior to or after reinstatement, to ensure that the applicant is competent.

3903.6 The Commissioner shall not reinstate an expired license of a public insurance adjuster who fails to apply for reinstatement of the expired public insurance adjuster license within one (1) year from the date of the expiration of the license. A person who fails to apply for reinstatement within the one-year period may become licensed by meeting the requirements then in existence for obtaining an initial license.

3904 REINSTATEMENT AFTER SUSPENSION OR REVOCATION

3904.1 A person whose license to do business as a public insurance adjuster has been revoked shall be ineligible to apply for licensure as a public insurance adjuster for a period of three (3) years from the date of the revocation unless otherwise provided in the Commissioner's order of revocation.

3904.2 An applicant for the reinstatement of a suspended or revoked license shall file an application with the Department on the prescribed form and shall pay the required reinstatement fee.

3904.3 An applicant for the reinstatement of a suspended or revoked license shall demonstrate fitness to transact business as a public insurance adjuster by submitting evidence satisfactory to the Commissioner that the applicant is not dishonest, untrustworthy or incompetent, and will not be detrimental to the public interest or the integrity of the insurance adjusting profession.

3904.4 In making a determination pursuant to this section, the Commissioner may consider, among other factors, the following:

(a) The nature and circumstances of the conduct for which the applicant's license was suspended or revoked;

(b) The applicant's recognition of the seriousness of any misconduct;

(c) The applicant's conduct since the suspension or revocation, including steps taken by the applicant to remedy prior misconduct

and prevent future misconduct;

(d) The applicant's present character;

(e) The applicant's present qualifications and competency to practice in the insurance adjusting profession; and

(f) Whether the applicant has paid all fines.

3904.5 The Commissioner may require an applicant to complete specific educational or training requirements, or to pass the public insurance adjuster examination, prior to or after reinstatement, to ensure that the applicant is competent.

3905 ESCROW OR TRUST ACCOUNTS

3905.1 Any public insurance adjuster who receives, accepts or holds any moneys, on behalf of an insured, towards the settlement of a claim for loss or damage, shall deposit such moneys in an interest bearing escrow or trust account in a financial institution in the District of Columbia which is insured by an agency of the Federal government.

3905.2 Any funds held in an escrow or trust account and interest accruing thereon shall be the property of the insured.

(a) Such moneys shall be held pursuant to a written agreement signed by the insured and by the public insurance adjuster which shall clearly specify:

(1) The services to be rendered; and

(2) The amount of any services to be paid from the escrowed funds.

(b) In the event of the insolvency and/or bankruptcy of a public insurance adjuster, the claim of an insured for any settlement moneys received, accepted or held by a public insurance adjuster shall constitute a statutory trust as provided at D.C. Official Code § 19-1102.

3906 MINIMUM RECORD KEEPING REQUIREMENTS

3906.1 Each licensee shall maintain accurate files, books and records reflecting all insurance-related transactions in which the licensee or his or her employees take part. These records shall be maintained by either separate books of record or by one or more consolidated books of record for a period of five years from the date of the closing of the claim.

(a) All books and records shall consist of sequentially numbered pages and shall be maintained in such a manner that they can be produced for examination

at any time.

(b) Appropriate and required entries shall be made promptly.

3906.2 Each licensee shall maintain a register of all monies received, deposited, disbursed or withdrawn in connection with a transaction with an insured, including, but not limited to: fees, transfers and disbursements from a trust account; and all transactions concerning, including the balance of, all interest bearing accounts. The minimum information required to be maintained in the register includes the following:

(a) The name and location of the financial institution in which the funds are deposited;

(b) The account number of the trust or escrow account;

(c) The date monies are received, deposited, disbursed or withdrawn;

(d) The amount of money received, deposited, disbursed or withdrawn;

(e) An itemized record of the allocation of the funds;

(f) The name of the insured, insurance producer, insurer or other account to or from whom monies are disbursed or received;

(g) The claim number assigned by the insurer;

(h) The receipt number, when available; and

(i) The method of payment, such as, cash, check, money order or draft.

3906.3 For each disbursement, the number of the check shall be recorded in the register.

3906.4 All entries for receipts and disbursements shall be supported by evidential matter as provided in § 3906.2 (b) and (c). The evidential matter shall be referenced in the entry so that it may be traced for verification.

3906.5 Each licensee shall prepare and maintain a monthly reconciliation of the trust account.

3906.6 Each licensee shall maintain a file for each claimant with whom a contractual relationship has been established. The minimum items required to be maintained in the file include:

(a) Correspondence received or sent with respect to any insurance or insurance-

related transaction;

(b) All of the client's contracts; and

(c) All other information related to the claim.

3906.7 The licensee shall also maintain the following records for a period of five years:

(a) Escrow or trust account statements;

(b) Names and addresses of all licensees;

(c) Copies of all new and renewal applications submitted to the Department by an individual and/or company;

(d) All fees received, if not deposited in a trust or escrow account; and

(e) All records of transactions with persons or entities owned by the licensee or by one or more of its officers or directors or an owner of 10 percent or more of the licensee that are construction firms, salvage firms or appraisal firms.

3906.8 Failure to keep, maintain or make available for inspection by the Commissioner, those records which the Commissioner shall require to be maintained in accordance with this section, or any other violations by a licensee, shall constitute a violation of D.C. Official Code § 31-1631.06.

3907 VIOLATIONS AND PENALTIES

3907.1 The Commissioner may deny, suspend, revoke, refuse to renew a public insurance adjuster's license, or impose a civil penalty based on any violation of the Act or these rules, or for the commission or omission of any act by a public insurance adjuster which demonstrates that the applicant or licensee is not competent or trustworthy to act as a public insurance adjuster, or where the person has:

(a) Violated any provision of the District's insurance laws, including any rules promulgated thereunder;

(b) Violated any provision of the Act, including any rules promulgated thereunder;

(c) Committed a fraudulent or dishonest act;

(d) Demonstrated the licensee's lack of integrity, incompetency, bad faith, dishonesty, financial irresponsibility or untrustworthiness to act as a public insurance adjuster;

- (e) Aided, abetted or assisted another person in violating any insurance law of the District or any state;
 - (f) Withheld material information or made a material misstatement in the application for licensure;
 - (g) Failed to pay any fine or comply with an order of the Commissioner;
 - (h) Charged or collected from any client any fee other than that agreed to in the employment contract in a form required in section 3909;
 - (i) Misappropriated, converted or illegally withheld, money which was received in the conduct of business as a public insurance adjuster that belonged to insurers, clients or others;
 - (j) Failed to notify the Commissioner within 30 days of a conviction for any misdemeanor (except minor traffic offense) or felony conviction, the suspension or revocation of any insurance license or public insurance adjusters license, or failed to supply any documentation that the Commissioner may request in connection therewith;
 - (k) Failed to appear in response to any subpoena issued by the Commissioner or his authorized designee; failed to produce any documents or other material requested in a subpoena; or refused or failed to cooperate with an investigation by the Commissioner of the activities of the person or any other licensee;
 - (l) Induced the cancellation of a duly executed written memorandum between an insured and a public insurance adjuster;
 - (m) Made any misrepresentation of facts or advised any person on questions of law in conjunction with the business as a public insurance adjuster;
 - (n) Had any professional license suspended or revoked in the District or in any state;
 - (o) Engaged in the business of a public insurance adjuster in the District or other jurisdiction without a valid license; or
 - (p) Committed any other act, or omission which the Commissioner determines to be inappropriate conduct by a licensee of the District.
- 3907.2 Notwithstanding the bases for disciplinary action provided in subsection 3907.1, the Commissioner may also deny, suspend, revoke, refuse to renew, or impose a civil penalty on a public insurance adjuster's license for the following prohibited practices:

- (a) No public insurance adjuster shall pay any money or give anything of value to any person in consideration of a direct or indirect referral of a client or potential client.
- (b) No public insurance adjuster shall pay any money or give anything of value to any person as an inducement to refer business or clients.
- (c) No public insurance adjuster shall charge, collect, or receive any money or other thing of value from any person providing services to the insured, either directly or on behalf of the public insurance adjuster, in connection with the business of adjusting insurance claims, without the prior written disclosure of the fee or benefit to the insured.
- (d) No public insurance adjuster shall rebate to a client any part of a fee specified in any employment contract.
- (e) No public insurance adjuster shall split his fee or pay any money to any person for services rendered to a client unless such other person is also licensed as a public insurance adjuster.
- (f) No public insurance adjuster licensed in the District shall have any interest directly or indirectly in any home improvement, restoration, construction, salvage, or appraisal business that conducts business in the District.
- (g) No public insurance adjuster shall, in connection with the transaction of his or her business as a public insurance adjuster, make any misrepresentation of facts or advise any person on any question of law.
- (h) No public insurance adjuster shall make any false statements about any insurance company or its employees, agents or representatives.
- (i) No public insurance adjuster shall solicit employment of a client in connection with any loss which is the subject of an employment contract with another public insurance adjuster.
- (j) No public insurance adjuster shall represent both an insurer and insured simultaneously.
- (k) No public insurance adjuster shall advance any monies to a client pending the settlement of a loss where such amount would be included in a final settlement.

3908 DISCLOSURES

- 3908.1 A public insurance adjuster shall disclose in writing to the client any interest the public insurance adjuster has in loss proceeds other than those acquired by his employment contract.
- 3908.2 A public insurance adjuster in soliciting a client for employment shall display his license and immediately inform such client that the adjuster does not represent any insurance company, or insurance company adjusting firm. The public insurance adjuster shall inform such client that his services are available for a fee to be paid by the client, and shall give such client a card identifying the public insurance adjuster and specifying on such card the amount of fee charged by the public insurance adjuster.

3909 FORM OF CONTRACT

No public insurance adjuster shall enter into an employment contract except in conformity with these rules. There shall be a true copy of the employment contract which shall be given to the client at the time the contract is signed. The contract and copy(ies) of the contract shall (1) be printed on white or cream paper in dark or black ink; (2) have section titles captioned in bold face type which otherwise stands out significantly from the text; (3) have statements on contract which read "read both sides before signing" and "I have read the information on both sides of this contract" printed in 18 point type; (4) use layout and spacing which separates the paragraphs from each other and from the border of the paper; (5) be on one piece of paper measuring 8 1/2" X 11" to be printed on both sides and which shall state:

(1) On side one:

INFORMATION ABOUT YOUR PUBLIC INSURANCE ADJUSTER EMPLOYMENT CONTRACT

YOUR LEGAL RIGHTS:

Cancellation: You may cancel this contract by notifying us at the address shown on the other side of this page, in writing, by certified mail, return receipt, postmarked not later than midnight three (3) business days following the day this contract is signed.

Settlement offer: We shall forward to you any written settlement offer from the insurance company.

Fee: Our services are available for a fee to be paid by you. We cannot charge or otherwise collect a fee that exceeds ten percent (10%) of the total recovery.

Copy of the contract: We must give you a true copy of this Public Insurance Adjuster Contract at the time you sign it.

LIMITATIONS OF PUBLIC INSURANCE ADJUSTERS:

We are not allowed:

- to solicit your employment if you have already hired or contracted with another public insurance adjuster.
- to have any interest whatsoever in any home improvement, restoration, construction, salvage, or appraisal business operating in the District.
- to represent both an insurer and an insured at the same time.
- to pay anything of value to any person as an inducement to refer business to us.
- to share our fee, except with another licensed Public Insurance Adjuster.
- to advise you on any question of law.
- to advance any monies to you before settlement of the loss, where such amount would be included in the final settlement.
- to make false statements about an insurance company or its representatives.

We must:

- sign this Contract.
- inform you that we do not represent any insurance company or any insurance company adjusting firm.

(2) On side two:

* NAME OF LICENSED PUBLIC INSURANCE ADJUSTER

* The name of the licensee must appear here. If you operate as a firm or on behalf of a firm, show name of firm licensee here and names of all individual licensees in designated area.

ADDRESS

TELEPHONE NUMBER

Names of individual public insurance

Adjuster licensee(s) to appear here

READ BOTH SIDES BEFORE SIGNING (18 point type)

PUBLIC INSURANCE ADJUSTER CONTRACT

To the Interested Insurance Companies and Others Whom it May Concern:

I/we retain (name of public insurance adjuster) to act as my/our public insurance adjuster(s) and to advise and assist in the adjustment and settlement of my/our (type) loss at (address) which occurred on or about (date). In consideration for these services, I/we hereby assign out of the monies due or to become due from said Insurance Companies on account of the said loss a sum equivalent to 10% percent of the total insurance recovery.

I HAVE READ THE INFORMATION ON BOTH SIDES OF THIS CONTRACT (18 point type)

(date)

Signed: (signature of insured)

(signature of insured)

(name)

(address)

(city & state)

Agreed to: (name of individual or firm licensee)

By: (signature of Public Insurance Adjuster)

This form is in compliance with Title 26, section 3909 (form of contract) of the DCMR. This form must be signed by the licensed Public Insurance Adjuster and the Insured.

3999 DEFINITIONS

3999.1 For the purposes of this chapter, the following words and phrases shall have meaning ascribed in this section:

“Act” -- the Public Insurance Adjuster Licensure Act of 2002, effective March 27, 2003 (D.C. Law 14-256; D.C. Official Code § 31-1631.01 et seq.).

“Department” -- the District of Columbia Department of Insurance and Securities Regulation.

“Person” – includes all natural persons, corporations, associations, limited liability companies, limited liability partnerships, joint ventures, exchanges, partnerships, limited partnerships, or other entities.

DISTRICT OF COLUMBIA
DEPARTMENT OF MOTOR VEHICLESNOTICE OF FINAL RULEMAKING

The Director of the Department of Motor Vehicles, pursuant to the authority set forth in Section 1425 of the Department of Motor Vehicles Establishment Act of 1998, effective March 26, 1999, 45 DCR 4794 (D.C. Law 12-175; D.C. Official Code § 50-901 *et seq.*) (2001 Ed.), Mayor's Order 94-176, effective August 19, 1994; section 7 of the District of Columbia Traffic Act of 1925, approved March 3, 1925 (43 Stat. 1121, D.C. Official Code § 50-1401.01(a) (200 Ed.)), and 18 DCMR 104.9, hereby gives notice of the adoption of the following rulemaking that amends Chapters 1, 3, 4, 7, 10, 26, and 30, of Title 18 of the District of Columbia Municipal Regulations (DCMR) (Vehicles and Traffic). The amendments provide that the Director may require an applicant for reinstatement to pass a breathalyzer test, establish grounds for the waiver of written and road tests for driver licenses, recognize road tests taken in Maryland or Virginia for applicants for motorcycle endorsements, place a new restriction on road tests in the District, require notification if a person develops certain medical conditions after license issuance, provide that persons applying to register their vehicle obtain a District of Columbia operator's permit when required to do so, and increase the traffic adjudication appeal transcript deposit fee to \$50. The rulemaking also corrects some inaccuracies in the traffic regulations resulting from recent legislative changes, including legislation regarding the tinting of motor vehicle windows. In addition, Section 3014 was rewritten to correct a codification error and to clarify the intent of the Director.

A notice of proposed rulemaking was published in the *D.C. Register* on April 18, 2003, at 50 DCR 3055. No comments were received regarding these proposed rules.

The Department chose to modify several portions of the proposed rulemaking. Section C of the proposed rules would have required a person to either obtain a D.C. operator's permit or non-driver identification card in order to register their motor vehicle. The requirement that a non-driver identification card be obtained was dropped because it was determined that such a requirement was not necessary where a person otherwise submits proof of residency. Section C was also clarified to provide that a person who has an out of state operator's permit must surrender that permit to obtain D.C. registration. Originally, the proposed rules required a person to submit a special identification card or D.C. driver's operator's permit. The goal in requiring a proof of a local permit was to prevent a resident from retaining their permit from another jurisdiction. Such retention makes it difficult to track violations and fails to ensure that a resident is subject to local permit suspension or revocation rules. The Department altered the language to better ensure that this does not come to pass.

In addition, the Section A of the proposed rulemaking provided that a driver developing a physical condition covered by §§ 105 or 106 had to immediately surrender their operator's permit and then come into compliance with the applicable regulations governing medical conditions that may impair driving ability. The final version instead gives the person 30 days from the date they learn

of their condition to come into compliance with the regulations. Only after the thirty-day period has expired and they still have not come into compliance with the applicable section must they surrender their permit. This will help ensure that driver's have an opportunity to establish that they do not represent a danger to the public before they must surrender their permit. This does not affect the ability of the Director, pursuant to § 302.2, to revoke or suspend a driver's license if it is clear that a driver jeopardizes the safety of persons or property.

Several minor grammatical changes were also made to the text of the proposed rule.

These final rules will be effective upon publication of this notice in the *D.C. Register*.

Title 18, DCMR, is amended as follows:

A. Chapter 1, ISSUANCE OF DRIVER'S LICENSES, is amended as follows:

1) Section 104, EXAMINATION OF APPLICANTS FOR DRIVER'S LICENSES, is amended as follows:

(a) By amending subsection 104.9 to read as follows:

104.9 Except as provided in section 111, the Director or his or her designee is authorized to exercise discretion and waive the written test or the road test to an applicant presenting an expired permit as follows:

- (a) The written examination may be waived if the applicant presents a District driver's license that has expired for a period of ninety (90) days or less;
- (b) Except as provided in (c), the road test may be waived if the applicant presents a driver's license issued by the District or any other jurisdiction, including a foreign country that has expired for period of one hundred and eighty (180) days or less; and
- (c) If the applicant, within two (2) years prior to date of the application, has been adjudicated or deemed liable for any moving violations for which points are assessable, and such points have not been waived, the road test may only be waived if the permit has been expired for a period of ninety (90) days or less.

(b) By amending subsection 104.10 by striking the phrase: "who are seventy-five (75) years of age or over".

(c) By adding a new subsection 104.12 to read as follows:

104.12 No road test shall be given to an applicant who drives himself or herself to the road test unaccompanied by a person with a valid driver's license. Any

applicant who violates this section shall not be permitted to take the road test for six (6) months.

2) Section 105 is amended by adding new subsections 105.10 through 105.14 to read as follows:

- 105.10 Any permittee who develops glaucoma, cataracts or loses functioning in one eye shall, within thirty (30) days of learning of the condition, appear at the Department with a medical eye report completed by an ophthalmologist on a medical form supplied by the Department.
- 105.11 Any permittee whose corrected visual acuity or field of vision becomes less than the minimum allowed under § 105.6 shall report to the Department for re-testing within thirty (30) days of learning of the condition.
- 105.12 The Director may reissue a license with conditions or revoke the license of a permittee who no longer meets the visual acuity requirements of § 105.6 or who submits information pursuant to § 105.10 that indicates that the person is not physically qualified to operate a motor vehicle in a manner not to jeopardize the safety of individuals or property.
- 105.13 Failure to appear when required by §§ 105.10 or 105.11 may be grounds for revocation pursuant to § 302.2.
- 105.14 The Director may suspend a driver's permit if more time is required to evaluate the permittee and may, in his or her discretion, issue a temporary license to a permittee if consistent with public safety.

3) Section 106 is amended by adding new subsections 106.12 through 106.16 to read as follows:

- 106.12 Any permittee who develops a physical condition covered by this section shall, within thirty (30) days of learning of the condition, appear at the Department, in accordance with the following:
- (a) Any permittee who develops diabetes shall furnish the medical report required by § 106.2, and shall be referred to the Medical Board if required by §§ 106.2 or 106.3; or
 - (b) Any permittee who experiences a loss of consciousness or a seizure shall furnish a medical report that meets the requirements of §§ 106.7 or 106.9.
- 106.13 Following review of the permittee's medical condition, the Director may either allow the license to remain in place, reissue the license with conditions necessary to ensure the safety of individuals and property, or

revoke the license if the person is not physically qualified to operate a motor vehicle in a manner not to jeopardize the safety of individuals or property.

106.14 Failure to appear when required by § 106.12 may be grounds for revocation pursuant to § 302.2.

106.15 The Director may suspend a driver's permit if more time is required to evaluate a permittee and may, in his or her discretion, issue a temporary license to a permittee if consistent with public safety.

4) Section 107, LICENSES ISSUED TO DRIVERS, subsection 107.13, is amended to read as follows:

107.13 Any person who has been issued a valid District of Columbia driver's license may have the license endorsed for the operation of motorcycles, upon successful completion of an examination required by the Director pursuant to § 104 and subject to the provision of § 103; except that if an applicant for a motorcycle license endorsement completed a motorcycle demonstration course in Virginia or Maryland, the demonstration requirement of § 104.3 may be waived by the Director, provided that (1) the course was completed within six (6) months of the person's application for a District of Columbia motorcycle endorsement, and (2) the person presents a certificate of successful completion of the course.

B. Chapter 3, CANCELLATION, SUSPENSION, OR REVOCATION OF LICENSES, Section 306, PERIOD OF SUSPENSION OR REVOCATION, is amended by adding a new subsection 306.9, to read as follows:

306.9 An applicant for reinstatement after a suspension or revocation for an alcohol-related offense may be required to pass a breathalyzer test, at the discretion of the Director.

C. Chapter 4, MOTOR VEHICLE TITLE AND REGISTRATION, Section 412, REFUSAL OF REGISTRATION, subsection 412.1 is amended by adding new paragraphs (l) and (m) to read as follows:

(l) If a person holds an out-of-state operator's permit and fails to surrender that permit to the Department.

(m) If a person is not domiciled in the District of Columbia.

D. Chapter 7, MOTOR VEHICLE EQUIPMENT, section 734, is amended as follows:

1) Subsection 734.8 is amended to read as follows:

734.8 No motor vehicle may be operated or parked upon the public streets or spaces of the District of Columbia with window tinting in violation of D.C. Code § 50-2207.02 (2001 Ed.).

2) Subsections 734.9 through 734.19 repealed.

E. Chapter 10, PROCEDURES FOR ADMINISTRATIVE HEARINGS, Section 1016, STYLE OF PLEADINGS AND PETITIONS, subsection 1016.1 is amended by striking the words "Public Works" and inserting the words "Motor Vehicles".

F. Chapter 26, Section 2601, PARKING AND OTHER NON-MOVING INFRACTIONS, is amended to include in the list of fines the following:

Glazing Materials [D.C. Code § 50-2207.02 (2001 Ed.)]	\$50.00
Failure to correct, first occasion	\$1,000.00
Failure to correct, second or subsequent occasion	\$5,000.00

G. Chapter 30, ADJUDICATION AND ENFORCEMENT, is amended as follows:

1) Section 3014, APPEALS, subsection 3014.10, is amended to read as follows:

- 3014.10 The appeal shall be considered filed when all of the following conditions are satisfied:
- (a) The fines and penalties assessed by the hearing examiner have been paid by the respondent;
 - (b) The appeal fee, required by § 3015, has been paid by the respondent;
 - (c) The deposit for the transcript, required by § 3017, has been paid by the respondent; and
 - (d) A notice of appeal form has been completed and submitted.

2) Section 3017, TRANSCRIPTS OF HEARINGS, subsection 3017.3 is amended by striking the phrase "thirty dollars (\$30)" and inserting the phrase "fifty dollars (\$50)".