

DEPARTMENT OF HEALTH
NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in Section 5(a) of the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984, D.C. Law 5-48, D.C. Official Code Section 44-501 *et seq.*, Section 44-504(a), and in accordance with Mayor's Order 98-137, dated August 30, 1998, hereby gives notice of the adoption of the following amendments to Chapters 20, 21, and 22 of Title 22 of the District of Columbia Municipal Regulations (DCMR). These amendments are made to conform to the Health Occupations Revision Act of 1985, effective March 25, 1986, D.C. Law 6-99, D.C. Official Code Section 3-1201.01 *et seq.*, and subsequent amendments thereto, which authorize other qualified health professionals to perform duties formerly done only by physicians. The amendments also require physicians to have an annual health examination performed by another physician.

The amendments were published as proposed in the *D.C. Register* on August 10, 2001, at 48 DCR 7320. No comments were received. Transmission of these amendments to the D.C. Council for review was inadvertently delayed. Having now undergone the required period of Council review, the rules were deemed approved by the D.C. Council on May 15, 2003.

Chapters 20, 21, and 22 (Hospitals) of Title 22 of the DCMR are amended as follows:

1. Section 2099 is amended by adding the following definitions:

Physician - a person currently licensed or registered pursuant to the Health Occupations Revision Act of 1985, effective March 25, 1986, D.C. Law 6-99, D.C. Official Code Section 3-1201.01 *et seq.*, to practice medicine and surgery, or a person licensed in another jurisdiction whose application for a license or registration is pending in the District.

Qualified Health Professional - a person licensed pursuant to the Health Occupations Revision Act of 1985, effective March 25, 1986, D.C. Law 6-99, D.C. Official Code Section 3-1201.01 *et seq.*, to practice a health occupation in the District, and authorized under the terms of that Act to perform the activity referred to in the particular regulation.

2. The following subsections of Chapter 21 are amended to read as follows:

2100.2 The governing body shall do the following:

- (a) Appoint an individual who shall be responsible for the administration of the hospital according to the requirements of this chapter and the policies and directives of the governing body;

- (b) Adopt administrative policies and rules for the operation of the hospital;
 - (c) Establish a medical staff composed of physicians, allied practitioners, and other qualified health professionals who accept the responsibility for the medical and dental care of patients;
 - (d) Require the medical staff to be organized with a chief of staff, president, or chairperson, and to be governed by written by-laws;
 - (e) Notify the Health Regulation Administration of the Department of Health within 24 hours of any changes in Chief Executive Officer, Medical Director, or Director of Nursing; and
 - (f) Hold bodies in the morgue no longer than 30 days.
- 2101.3** Each licensee shall require all employees, contract workers, and volunteers working in the hospital to familiarize themselves with the provisions of this chapter and with all other regulations applicable to their duties.
- 2102.1** Each person, other than a physician, involved in the performance of duties involving direct patient care shall have a health examination by a physician or other qualified health professional within fifteen (15) calendar days prior to entering active status or within fifteen (15) calendar days after entering, and annually thereafter. Each physician shall have a health examination performed by another physician at the time of appointment and annually thereafter.
- 2102.3** Each person who has a positive reaction to the intradermal tuberculin test, or who has a history of positive reaction to the intradermal tuberculin test, shall receive a chest x-ray. The frequency of chest x-rays shall be at the examining physician's discretion. The examining physician shall note the reason for taking or deferring the x-ray in the examination record.
- 2102.4** A report, signed by an examining physician or other qualified health professional, shall be made of each examination.
- 2103.1** Each person who is involved in direct patient care and who has been absent from duty because of an illness required to be reported to the Department shall, prior to returning to duty, obtain certification from a physician or other qualified health professional, as provided for in the hospital's policies, that he or she can return to duty without apparent danger of transmitting the cause of the illness to any patient.
- 2108.3** No patient shall be placed in mechanical restraint or other seclusion, unless ordered by a physician or other qualified health professional, and unless a nurse or attendant is continuously on duty in charge of and responsible for the patient.

- 2109.1** Each patient on admission, or as soon after admission as is feasible, shall have a medical history taken, a physical examination, a blood count and urinalysis (except in the case of newborn infants), and a medical record initiated; Provided that, in accordance with the established policy of the hospital, the physical examination, blood count, or urinalysis may be omitted under the following conditions:
- (a) The physician, dentist, or other qualified health professional certifies in the new medical record that the examination or test has been previously made and that the results of it are available to provide the essential information necessary for the proper care and treatment of the patient;
 - (b) The physician, dentist, or other qualified health professional includes the essential parts of the previous examination or test in the new medical record; and
 - (c) The physician, dentist, or other qualified health professional documents in the new medical record that the examination or test is therefore not required.
- 2110.1** Except in the case of emergency, no medication or treatment other than dental shall be given to any patient without an order of a physician or other qualified health professional.
- 2110.2** No dental medication or treatment shall be given to any patient without an order of a dentist, physician, or other qualified health professional, except in an emergency.
- 2110.3** The physician's, dentist's, or other qualified health professional's order shall be recorded at the time it is made and shall be signed by the physician, dentist, or other qualified health professional as soon as practicable.

3. The title of section 2101 is amended to read as follows:

Hospital Staff and Other Persons With Hospital Duties

4. The title of section 2103 is amended to read as follows:

Other Direct Care Persons Health Requirements

5. The following subsections of Chapter 22 are amended to read as follows:

- 2200.3** Except in an emergency, no spinal or general anesthesia shall be given to any patient until the patient's condition for anesthesia has been evaluated by a physician or other

qualified health professional, and the necessary laboratory studies, including blood count and urinalysis, have been completed.

- 2203.5** There shall be at least one (1) staff or resident physician, or other qualified health professional, assigned to the newborn service, who will be on call at all times and who will visit the newborn unit at regular intervals and a minimum of one (1) time each day.
- 2213.3** No drugs shall be issued from any hospital pharmacy except under supervision of a pharmacist, a physician, or another qualified health professional, and a record shall be kept of each pharmaceutical issued from the pharmacy for the period of time required by the provisions of law applicable to the particular pharmaceutical issued.

-DEPARTMENT OF INSURANCE AND SECURITIES REGULATION

NOTICE OF FINAL RULEMAKING

The Commissioner of Insurance and Securities Regulation ("Commissioner"), pursuant to the authority set forth in sections 4, 5, 6, 9 and 11 of the Medicare Supplement Insurance Minimum Standards Act of 1992, effective July 22, 1992 (D.C. Law 9-170, D.C. Official Code §§ 31-3703, 31-3704, 31-3705, 31-3708 and 31-3710 (2001)), and Mayor's Order 93-60, dated May 12, 1993, hereby gives notice of the adoption of an amendment to Chapter 22 (Medicare Supplement Insurance Minimum Standards) of Title 26 of the District of Columbia Municipal Regulation (DCMR) (Insurance).

The emergency action is necessary to ensure that the District's regulations regarding minimum standards for Medicare supplement insurance conform to the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA"), enacted in § 1 (a) of the Fiscal Year 2001 Consolidated Appropriations Act, approved December 21, 2000 (Pub. L. 106-554; 114 Stat. 2763). Without this emergency action, the District of Columbia will not maintain certification of its regulatory programs, thereby resulting in an adverse effect on the health, safety and welfare of residents of the District of Columbia

A notice of emergency and proposed rules was published in the D.C. Register on February 7, 2003 (50 DCR 1248). 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.

26 DCMR, Chapter 22 (Medicare Supplement Insurance Minimum Standards) is amended to read as follows:

Chapter 22 MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS**2200 PURPOSE**

2200.1 The purpose of this chapter is:

- (a) To provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies;
- (b) To facilitate public understanding and comparison of such policies;
- (c) To eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and
- (d) To provide for full disclosure in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

2201 AUTHORITY

This chapter is issued pursuant to the authority vested in the Commissioner of Insurance and Securities Regulation under the Medicare Supplement Insurance Minimum Guidelines Act of 1992, effective July 22, 1992 (D.C. Law 9-170; D.C. Official Code § 31-3701 et seq.).

2202 APPLICABILITY AND SCOPE

2202.1 Except as otherwise specifically provided in sections 2206, 2209, 2211, 2217 and 2225, this chapter shall apply to:

- (a) All Medicare supplement policies delivered or issued for delivery in the District of Columbia on or after May 1, 1999; and
- (b) All certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in the District.

2202.2 This chapter shall not apply to:

- (a) A policy or contract of one or more employers or labor organizations; or
- (b) The trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

2203 RESERVED**2204 POLICY DEFINITIONS AND TERMS**

2204.1 No policy or certificate may be advertised, solicited or issued for delivery in the District as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this section.

2204.2 "Accident", "accidental injury", or "accidental means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

- (a) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."
- (b) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

2204.3 "Benefit period" or "Medicare benefit period" shall not be defined more

restrictively than as defined in the Medicare program.

- 2204.4 "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.
- 2204.5 "Health care expenses" means expenses of health maintenance organizations associated with the delivery of health care services, which are analogous to incurred losses of insurers. Expenses shall not include:
- (a) Home office and overhead costs;
 - (b) Advertising costs;
 - (c) Commissions and other acquisition costs;
 - (d) Taxes;
 - (e) Capital costs;
 - (f) Administrative costs; and
 - (g) Claims processing costs.
- 2204.6 "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare Program.
- 2204.7 "Medicare" shall be defined in the policy and certificate and may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public L. No. 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.
- 2204.8 "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.
- 2204.9 "Physician" shall not be defined more restrictively than as defined in the Medicare program.
- 2204.10 "Sickness" shall not be defined more restrictively than the following:
- An illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force; and
- The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

2205 POLICY PROVISIONS

- 2205.1 Except for permitted preexisting condition clauses as described in subsections

2206.4 and 2207.4 of this chapter, no policy or certificate may be advertised, solicited or issued for delivery in the District as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

2205.2 No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

2205.3 No Medicare supplement policy or certificate in force in the District shall contain benefits which duplicate benefits provided by Medicare.

2206 MINIMUM BENEFIT STANDARDS FOR POLICIES OR CERTIFICATES ISSUED FOR DELIVERY PRIOR TO MAY 1, 1999

2206.1 No policy or certificate may be advertised, solicited or issued for delivery in the District as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards.

2206.2 The standards contained in subsections 2206.3 through 2206.13 are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

2206.3 The following General Standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this chapter.

2206.4 A Medicare supplement policy or certificate shall not:

- (a) Exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition; and
- (b) Define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2206.5 A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

2206.6 A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors, and premiums may be modified to correspond with such changes.

2206.7 A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

- (a) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or
- (b) Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

- 2206.8 Except as authorized by the Commissioner, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.
- 2206.9 If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subsection 2206.3(h), the issuer shall offer certificate holders an individual Medicare supplement policy and shall offer certificate holders at least the following choices:
- (a) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and
 - (b) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in subsection 2207.14 of this chapter.
- 2206.10 If membership in a group is terminated, the issuer shall:
- (a) Offer the certificate holder such conversion opportunities as are described subsection 2206.9; or
 - (b) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.
- 2206.11 If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.
- 2206.12 Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.
- 2206.13 The following Minimum Benefit Standards shall apply to Medicare supplement policies or certificates.
- (a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first (61st) day through the ninetieth (90th) day in any Medicare benefit period;
 - (b) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;
 - (c) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;
 - (d) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare

Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

- (e) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;
- (f) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible (\$100); and
- (g) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

2207 MINIMUM BENEFIT STANDARDS FOR POLICIES OR CERTIFICATES ISSUED OR DELIVERED ON OR AFTER MAY 1, 1999

- 2207.1 The standards contained in this section are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in the District of Columbia on or after May 1, 1999.
- 2207.2 No policy or certificate may be advertised, solicited, delivered or issued for delivery in the District as a Medicare supplement policy or certificate unless it complies with these benefit standards.
- 2207.3 The following General Standards apply to Medicare supplement policies or certificates and are in addition to all other requirements of this chapter:
- 2207.4 A Medicare supplement policy or certificate shall not:
- (a) Exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition; and
 - (b) Define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.
- 2207.5 A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
- 2207.6 A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors and premiums may be modified to correspond with such changes.
- 2207.7 No Medicare supplement policy or certificate shall provide for termination of

coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

2207.8

Each Medicare supplement policy shall be guaranteed renewable.

- (a) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.
- (b) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.
- (c) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subsection 2207.8(e), the issuer shall offer certificate holders an individual Medicare supplement policy which, at the option of the certificate holder,
 - (1) Provides for continuation of the benefits contained in the group policy, or
 - (2) Provides for such benefits or otherwise meets the requirements of this subsection.
- (d) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:
 - (1) Offer the certificate holder the conversion opportunity described in subsection 2207.8(c); or
 - (2) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.
- (e) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

2207.9

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

2207.10

A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period, not to exceed twenty-four (24) months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual

becomes entitled to such assistance.

- 2207.11 If such suspension occurs pursuant to subsection 2207.10 and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted, effective as of the date of termination of such entitlement, if the policyholder or certificate holder provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.
- 2207.12 Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for the period provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of such loss.
- 2207.13 Reinstitution of coverages:
- (a) Shall not provide for any waiting period with respect to treatment of preexisting conditions;
 - (b) Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and
 - (c) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.
- 2207.14 The following standards for Basic ("Core") Benefits, common to all benefit plans, shall apply:
- (a) Every issuer:
 - (1) Shall make available a policy or certificate including only the following Basic "Core" Package of Benefits, common to all benefits plans, to each prospective insured; and
 - (2) May make available to prospective insureds any of the other Medicare Supplement insurance Benefit Plans in addition to the Basic "Core" Package of Benefits, but not instead of the Basic "Core" package of Benefits.
 - (b) The Basic ("Core") Package of Benefits consists of the following:
 - (1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
 - (2) Coverage of Part A Medicare Eligible Expenses incurred for

hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

- (3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days; provided that the provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;
- (4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations; and
- (5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

2207.15

The following Additional Benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by section 2208 of this chapter:

- (a) Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period;
- (b) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;
- (c) Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;
- (d) Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;
- (e) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;
- (f) Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars (\$1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare;
- (g) Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent

(50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible to a maximum of three thousand dollars (\$3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare;

- (h) Medically Necessary Emergency Care in a Foreign Country : Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000). For purposes of paragraph (h), "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset;
- (i) Preventive Medical Care Benefit: Coverage for the following preventive health services:
- (1) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (2) and patient education to address preventive health care measures;
 - (2) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:
 - (A) Digital rectal examination;
 - (B) Dipstick urinalysis for hematuria, bacteriuria and proteinuria;
 - (C) Pure tone (air only) hearing screening test, administered or ordered by a physician;
 - (D) Serum cholesterol screening every five (5) years;
 - (E) Thyroid function test; and
 - (F) Diabetes screening.
 - (3) Tetanus and diphtheria booster (every ten (10) years);
 - (4) Any other tests or preventive measures determined appropriate by the attending physician.
 - (5) Reimbursement under this paragraph shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars (\$120) annually under this benefit. This benefit shall

not include payment for any procedure covered by Medicare.

- (j) At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(1) For purposes of this benefit, the following definitions shall apply:

- (A) "Activities of daily living" includes, but is not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;
- (B) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;
- (C) "Home" means any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence;
- (D) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except that each consecutive four (4) hours in a twenty-four (24) hour period of services provided by a care provider shall be considered as one visit.

(2) Coverage Requirements and Limitations:

- (A) At-home recovery services provided must be primarily services which assist in activities of daily living.
- (B) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare;
- (C) Coverage is limited to:
 - (i) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician and the total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;
 - (ii) The actual charges for each visit up to a maximum reimbursement of forty dollars (\$40) per visit;

- (iii) One thousand six hundred dollars (\$1,600) per calendar year;
- (iv) Seven (7) visits in any one week;
- (v) Care furnished on a visiting basis in the insured's home;
- (vi) Services provided by a care provider as defined in this section;
- (vii) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;
- (viii) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

(D) Coverage is excluded for:

- (i) Home care visits paid for by Medicare or other government programs; and
- (ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

- (k) New or Innovative Benefits: An issuer may, with the prior approval of the Commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards and the new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

2208 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS

- 2208.1 An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the Basic "Core" Benefits, as defined in subsection 2207.14.
- 2208.2 No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in the District, except as may be permitted in subsection 2207.15(k).
- 2208.3 Benefit plans shall be uniform in structure, language, designation and format to the Standard Benefit Plans "A" through "J" listed in this subsection and conform to the definitions in section 2299.
- 2208.4 Each benefit shall be structured in accordance with the format provided in

subsections 2207.14 and 2207.15 and list the benefits in the order shown in subsection 2208.7.

- 2208.5 For purposes of section 2208, "structure, language, and format" means style, arrangement and overall content of a benefit.
- 2208.6 An issuer may use, in addition to the benefit plan designations required in subsection 2208.3, other designations to the extent permitted under District law.
- 2208.7 Make-up of benefit plans:
- (a) Standardized Medicare supplement benefit plan "A" shall be limited to the Basic ("Core") Benefits common to all benefit plans, as defined in subsection 2207.14;
 - (b) Standardized Medicare supplement benefit plan "B" shall include only the following:
 - (1) The Core Benefit as defined in subsection 2207.14; plus
 - (2) The Medicare Part A Deductible as defined in subsection 2207.15(a).
 - (c) Standardized Medicare supplement benefit plan "C" shall include only the following:
 - (1) The Core Benefit as defined in subsection 2207.14; and
 - (2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a foreign Country as defined in subsection 2207.15(a), (b), (c) and (h);
 - (d) Standardized Medicare supplement benefit plan "D" shall include only the following:
 - (1) The Core Benefit as defined in subsection 2207.14; and
 - (2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in an foreign Country and the At-Home Recovery Benefit as defined in subsections 2207.15(a) and (b),(h), and (j);
 - (e) Standardized Medicare supplement benefit plan "E" shall include only the following:
 - (1) The Core Benefit as defined in subsection 2207.14; and
 - (2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a foreign Country and Preventive Medical Care as defined in subsection 2207.5(a), (b), (h), and (i);
 - (f) Standardized Medicare supplement benefit plan "F" shall include only the following:

- (1) The Core Benefit as defined in subsection 2207.14; and
 - (2) The Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a foreign Country as defined in subsections 2207.15(a), (b), (c), (e), and (h);
- (g) Standardized Medicare supplement benefit plan "G" shall include only the following:
- (1) The Core Benefit as defined in subsection 2207.14; and
 - (2) The Medicare Part A Deductible, the Skilled Nursing Facility Care, Eighty Percent (80%) of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in subsections 2207.15(a), (b), (d), (h), and (j);
- (h) Standardized Medicare supplement benefit plan "H" shall consist of only the following:
- (1) The Core Benefit as defined in subsection 2207.14; and
 - (2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in subsections 2207.15(a), (b), (f), and (h);
- (i) Standardized Medicare supplement benefit plan "I" shall consist of only the following:
- (1) The Core Benefit as defined in subsection 2207.14; and
 - (2) The Medicare Part A Deductible, Skilled Nursing Facility Care, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in subsections 2207.15(a), (b), (e), (f), (h), and (j).
- (j) Standardized Medicare supplement benefit plan "J" shall consist of only the following:
- (1) The Core Benefit as defined in subsection 2207.14; and
 - (2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in subsections 2207.15(a), (b), (c), (e), (g), (h), (i), and (j);

- (k) Standardized Medicare supplement benefit high deductible plan "F" shall include only 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in section 2207, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in subsections 2207.15(a), (b), (c), (e) and (h). The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses other than premiums for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be fifteen hundred dollars (\$1500) for 1998 and 1999, and shall be based on the calendar year. It shall include the annual adjustments made thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.
- (l) Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in section 2207 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in sections 2207.15(a), (b), (c), (d), (h), (i) and (j) respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses other than premiums for services covered by the Medicare supplement "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be fifteen hundred dollars (\$1500) for 1998 and 1999, and shall be based on the calendar year. It shall include the annual adjustments made thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10).

2209 GUARANTEED ISSUE FOR ELIGIBLE PERSONS

- 2209.1 An eligible person shall be any of the individuals described in subsection 2209.3 who apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in subsection 2209.3, and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.
- 2209.2 With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection 2209.4 that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.
- 2209.3 An eligible person is an individual described in any of the following:

- (a) The individual is enrolled under an employee welfare benefit plan providing health benefits which supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;
- (b) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare+Choice plan:
 - (1) The organization's or plan's certification has been terminated or otherwise discontinued providing the plan in the area in which the individual resides;
 - (2) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g) (3) (B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;
 - (3) The individual demonstrates, in accordance with guidelines established by the Secretary, that:
 - (A) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or
 - (B) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
 - (4) The individual meets such other exceptional conditions as the Secretary may provide.
- (c) The individual is:
 - (1) Enrolled with one of the following:
 - (A) An eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost);
 - (B) A similar organization operating under demonstration project authority, effective for periods beginning prior to

April 1, 1999;

- (C) An organization under an agreement under section 1833 (a) (1) (A) of the Social Security Act (Health care prepayment plan); or
- (D) An organization under a Medicare Select policy; and
- (2) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subsection 2209.3(b) of this chapter.
- (d) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:
 - (1) Of the insolvency of the issuer or bankruptcy of the nonissuer organization, or of other involuntary termination of coverage of enrollment under the policy;
 - (2) The issuer of the policy substantially violated a material provision of the policy; or
 - (3) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.
- (e) The individual:
 - (1) Was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls for the first time with any Medicare+ Choice organization under a Medicare+Choice plan under Part C of Medicare, any eligible organization under a contract under section 1876 (Medicare cost), any similar organization operating under demonstration project authority, an organization under an agreement under section 1833 (a) (1) (A) of the Social Security Act (health care prepayment plan), or a Medicare Select policy; and
 - (2) The subsequent enrollment under subparagraph (1) of this paragraph is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the Social Security Act); or
- (f) The individual, upon first becoming eligible for benefits under Part A of Medicare at age 65, enrolls in a Medicare+Choice plan under Part C of Medicare, and disenrolls from the plan by not later than twelve (12) months after the effective date of enrollment.

2209.4

The Medicare supplement policy to which an eligible person is entitled under:

- (a) Subsections 2209.3(a),(b),(c)and(d) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C or F offered by any issuer;

- (b) Subsections 2209.3(e) is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph (a) of this subsection;
- (c) Subsection 2209.3(f) shall include any Medicare supplement policy offered by any issuer.

2209.5

Notification shall be provided as follows:

- (a) At the time of an event described in subsection 2209.3 because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection 2209.2. Such notice shall be communicated contemporaneously with the notification of termination.
- (b) At the time of an event described in subsection 2209.3 because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection 2209.2. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

2209.6

Guaranteed issue time periods shall be as follows:

- (a) In the case of an individual described in subsection 2209.3(b), the guaranteed issue period begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation) and ends sixty-three (63) days after the date of the applicable notice;
- (b) In the case of an individual described in subsection 2209.3(b), 2209.3(c) 2209.3(e) or 2209.3(f) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;
- (c) In the case of an individual described in subsection 2209.3(d), the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuers' bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated;
- (d) In the case of an individual described in subsections 2209.3(b), 2209.3(d)(2), 2209.3(d)(3), 2209.3(e), 2209.3(f) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-

three (63) days after the effective date; and

- (e) In the case of an individual described in subsection 2209.3 but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.

2209.7 Extended Medigap access for interrupted trial periods shall be as follows:

- (a) In the case of an individual described in subsection 2209.3(e) (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in subsection 2209(e)(1) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in section 2209.3(e);
- (b) In the case of an individual described in subsection 2209.3(f) (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in subsection 2209.3(f) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in subsection 2209.3(f); and
- (c) For purposes of subsections 2209.3(e) and 2209.3(f), no enrollment of an individual with an organization or provider described in subsection 2209.3(e)(1), or with a plan or in a program described in subsection 2209.3(f), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

2210 OPEN ENROLLMENT

- 2210.1 No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in the District, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B.
- 2210.2 Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under subsection 2210.1 without regard to age.
- 2210.3 If an applicant qualifies under subsection 2210.1 and submits an application during the time period referenced in subsection 2210.1 and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

2210.4 If an applicant qualifies under subsection 2210.1 and submits an application during the time period referenced in subsection 2210.1 and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the

aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The manner of the reduction under this section shall be that specified by the Secretary.

2210.5 Except as provided in subsections 2210.3 and 2210.4, and section 2227, subsection 2210.1 shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

2211 STANDARDS FOR CLAIMS PAYMENT

2211.1 An issuer shall comply with section 1882(c) (3) of the Social Security Act (as enacted by section 4081(b) (2) (C) of the Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203) by:

- (a) Accepting a notice from a Medicare carrier on duly assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;
- (b) Notifying the participating physician or supplier and the beneficiary of the payment determination;
- (c) Paying the participating physician or supplier directly;
- (d) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;
- (e) Paying user fees for claim notices that are transmitted electronically or otherwise; and
- (f) Providing to the Secretary, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

2211.2 Compliance with the requirements set forth in subsection 2211.1 shall be certified on the Medicare supplement insurance experience reporting form.

2212 LOSS RATIO STANDARDS

2212.1 A Medicare supplement insurance policy form or certificate form shall not be delivered or issued for a delivery in the District unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits, (not including anticipated refunds or credits) provided under the policy form or certificate form:

- (a) At least seventy-five percent (75%) of the aggregate amount of premiums

earned in the case of group policies; or

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

2212.2 The loss ratios set forth in subsection 2212.1 shall be calculated on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums for the period and in accordance with accepted actuarial principles and practices.

2212.3 All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section 2212 when combined with actual experience to date.

2212.4 Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

2212.5 For purposes of applying subsections 2212.1, 2212.2 and section 2216 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising, including both print and broadcast advertising, shall be deemed to be individual policies.

2212.6 For policies issued prior to October 1, 1992 expected claims in relation to premiums shall meet:

- (a) The originally filed anticipated loss ratio when combined with the actual experience since inception;
- (b) The appropriate loss ratio requirement from subsection 2212.1(a) and (b) when combined with actual experience beginning with May 1, 1999 to date; and
- (c) The appropriate loss ratio requirement from subsection 2212.1(a) and (b) over the entire future period for which the rates are computed to provide coverage.

2213 REFUND OR CREDIT OF PREMIUM

2213.1 An issuer shall collect and file with the Commissioner by May 31 of each year the data contained in the reporting form contained in Appendix A for each type in a Standard Medicare Supplement Benefit Plan, described in section 2208.

2213.2 If on the basis of the experience as reported the benchmark loss ratio since inception (ratio 1) exceeds the adjusted experience loss ratio since inception (ratio 3), then a refund or credit calculation is required.

- (a) The refund calculation shall be done on a District-wide basis for each type in a standard Medicare supplement benefit plan.
- (b) For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

- (c) For purposes of this section, with regard to policies or certificates issued prior to July 22, 1992 the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined, and all group policies combined for experience after May 1, 1999. The first such report shall be due by May 31, 2001.

2213.4 A refund or credit shall be made only when:

- (a) The benchmark loss ratio exceeds the adjusted experience loss ratio; and
- (b) The amount to be refunded or credited exceeds a de minimis level.

2213.5 The refund or credit described in subsection 2213.4 shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary, but in no event shall it be less than the average rate of interest of thirteen (13) week Treasury notes.

2213.6 A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

2214 ANNUAL FILING OF PREMIUM RATES

2214.1 An issuer of Medicare supplement policies and certificates issued in the District before or after the effective date of this chapter shall file annually its rates, rating schedule and supporting documentation, including ratios of incurred losses to earned premiums by policy duration, for approval by the Commissioner of the Department of Insurance and Securities Regulation in accordance with the filing requirements and procedures prescribed by the Commissioner.

2214.2 The supporting documentation shall also demonstrate, in accordance with actuarial standards of practice using reasonable assumptions, that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed and such demonstration shall exclude active life reserves.

2214.3 An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

2214.4 As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in the District shall file with the Commissioner:

- (a) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates; and
- (b) Supporting documents as necessary to justify the adjustment.

2214.5 An issuer shall make premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies

and certificates.

2214.6 No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

2214.7 If an issuer fails to make acceptable premium adjustments, the Commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by section 2212.

2214.8 Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare and the riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

2215 PUBLIC HEARINGS.

2215.1 The Commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after July 22, 1992, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard.

2215.2 The determination of compliance shall be made without consideration of any refund or credit for such reporting period.

2215.3 Public notice of such hearing shall be furnished in a manner deemed appropriate by the Commissioner.

2216 FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES

2216.1 An issuer shall not:

- (a) Deliver or issue for delivery a policy or certificate to a resident of the District unless the policy form or certificate form has been filed with and approved by the Commissioner; and
- (b) Use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Commissioner.

2216.2 Except as provided in subsection 2216.3, an issuer shall not file for approval more than one form of a policy or certificate of each type for each Standard Medicare Supplement Benefit Plan described in section 2208.

2216.3 An issuer may offer, with the approval of the Commissioner, up to four (4) additional policy forms or certificate forms of the same type for the same Standard Medicare Supplement Benefit Plan, one for each of the following cases:

- (a) The inclusion of new or innovative benefits;
- (b) The addition of either direct response or agent marketing methods;

- (c) The addition of either guaranteed issue or underwritten coverage; and
- (d) The offering of coverage to individuals eligible for Medicare by reason of disability.

- 2216.4 For the purposes of this section 2216, a type means an individual policy or a group policy.
- 2216.5 Except as provided in subsections 2216.7 and 2216.8, an issuer shall continue to make available for purchase any policy form or certificate form issued after May 1, 1999 that has been approved by the Commissioner.
- 2216.6 A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.
- 2216.7 An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the Commissioner in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate.
- 2216.8 After receipt of the notice by the Commissioner, the issuer shall no longer offer for sale the policy form or certificate form in the District.
- 2216.9 An issuer that discontinues the availability of a policy form or certificate form pursuant to subsections 2216.7 and 2216.8 shall not file for approval a new policy form or certificate form of the same type for the same Standard Medicare Supplement Benefit Plan as the discontinued form for a period of five (5) years after the issuer provides notice to the Commissioner of the discontinuance.
- 2216.10.1 The period of discontinuance may be reduced if the Commissioner determines that a shorter period is appropriate.
- 2216.11 The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of subsections 2216.5, 2216.6, 2216.7, 2216.8, 2216.9, and 2216.10.
- 2216.12 A change in the rating structure or methodology shall be considered a discontinuance under subsections 2216.5, 2216.6, 2216.7, 2216.8, and 2216.9, and 2216.10, unless the issuer complies with the following requirements:
- (a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the Commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.
 - (b) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change; and
 - (c) The Commissioner may approve a change to the differential that is in the public interest.

2216.13 Except as provided in subsection 2216.11;

- (a) The experience of all policy forms or certificate forms of the same type in a Standard Medicare Supplement Benefit Plan shall be combined for purposes of the refund or credit calculation prescribed in section 2213;
- (b) Forms-assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation;
- (c) An issuer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after May 1, 1999 based upon a structure or methodology with any groupings of attained ages greater than one year. The ratio between rates for successive ages shall increase smoothly as age increases.

2217 PERMITTED COMPENSATION ARRANGEMENTS

2217.1 An issuer or other entity may provide a commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

2217.2 The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

2217.3 No issuer or other entity shall provide compensation to its agents or other producers, and no agent or producer shall receive compensation, greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

2217.4 For purposes of section 2217, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

2218 REQUIRED DISCLOSURE PROVISIONS - GENERAL RULES

2218.1 Medicare supplement policies and certificates shall include a renewal or continuation provision and the language or specifications of such provision shall be consistent with the type of contract issued.

2218.2 The renewal or continuation provision shall:

- (a) Be appropriately captioned;
- (b) Appear on the first page of the policy; and
- (c) Include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

2218.3 Except for riders or endorsements by which the issuer effectuates a request made

in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured.

- 2218.4 After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the Minimum Standards for Medicare Supplement Policies, or if the increased benefits or coverage is required by law.
- 2218.5 Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.
- 2218.6 Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.
- 2218.7 If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."
- 2218.8 Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate, or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.
- 2218.9 Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis, to a person or persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the United States Department of Health and Human Services, and in a type size no smaller than twelve (12) point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this chapter.
- (a) Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuer;
 - (b) Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered; and
 - (c) For the purpose of this section "form" means the language, format, type, size, type proportional spacing, bold character, and line spacing.

2219 REQUIRED DISCLOSURE PROVISIONS – NOTICE REQUIREMENT

- 2219.1 As soon as practicable, but no later than thirty (30) days prior to the annual

effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the Commissioner.

2219.2 Notice shall:

- (a) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and
- (b) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

2219.3 The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

2219.4 Such notices shall not contain or be accompanied by any solicitation.

2219.5 Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants A Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the United States Department of Health and Human Services, and in a type size no smaller than twelve (12) point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this chapter.

- (a) Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide shall be obtained by the issuer.
- (b) Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

2220 **REQUIRED DISCLOSURE PROVISIONS - OUTLINE OF COVERAGE REQUIREMENTS FOR MEDICARE SUPPLEMENT POLICIES.**

2220.1 Issuers shall:

- (a) Provide an outline of coverage to all applicants at the time the application is presented to the prospective applicant; and
- (b) Except for direct response policies, obtain an acknowledgment of receipt of such outline from the applicant.

2220.2 If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall:

- (a) Accompany such policy or certificate when it is delivered; and
- (b) Contain the following statement, in no less than twelve (12) point type,

immediately above the company name:

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

- 2220.3 The outline of coverage provided to applicants pursuant to section 2220 consists of four parts:
- (a) A cover page;
 - (b) Premium information;
 - (c) Disclosure pages; and
 - (d) Charts displaying the features of each benefit plan offered by the issuer.
- 2220.4 The outline of coverage shall be in the language and format prescribed in subsection 2220.9, in no less than twelve (12) point type.
- 2220.5 All plans A through J shall be shown on the cover page, and the plan(s) offered by the issuer shall be prominently identified.
- 2220.6 Premium information for plans offered shall be:
- (a) Shown on the cover page or immediately following the cover page; and
 - (b) Prominently displayed.
- 2220.7 The premium and mode shall be stated for all plans that are offered to the prospective applicant.
- 2220.8 All possible premiums for the prospective applicant shall be illustrated.
- 2220.9 The following items shall be included in the outline of coverage in the order prescribed below.

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page:

Benefit Plans _____ [insert letters of plans being offered]

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

Basic Benefits: Included in All Plans.

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

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses).

Blood: First three pints of blood each year.

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

PREMIUM INFORMATION [Boldface Type]

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

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

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

RIGHT TO RETURN POLICY [Boldface Type]

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

POLICY REPLACEMENT [Boldface Type]

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

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

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

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

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

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

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 9D of this regulation.]

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 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 \$[768] All but \$[192] a day All but \$[384] a day \$0 \$0	\$0 \$[192] a day \$[384] a day 100% of Medicare eligible expenses \$0	\$[768](Part A deductible) \$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 \$0 \$0	\$0 Up to \$[96] a day 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 A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physi- cian'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	\$0 Generally 20% \$0	\$100 (Part B deductible) \$0 All costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$100 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 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 \$[768] All but \$[192] a day All but \$[384] a day \$0 \$0	\$[768](Part A deductible) \$[192] a day \$[384] 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 100 th day 101st day and after	All approved amounts All but \$[96] a day \$0	\$0 \$0 \$0	\$0 Up to \$[96] a day 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 B

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

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

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

PARTS A & B

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

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 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 \$[768] All but \$[192] a day All but \$[384] a day \$0 \$0	\$[768](Part A deductible) \$[192] a day \$[384] 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 C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physi- cian'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% \$0	\$0 \$0 All costs
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

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$100 (Part B deductible) 20%	\$0 \$0 \$0
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OTHER BENEFITS—NOT COVERED BY MEDICARE

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 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 \$0 100% 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 D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physi- cian'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	 \$0 Generally 20% \$0	 \$100 (Part B deductible) \$0 All costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$100 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	 100%	 \$0	 \$0

(continued)

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$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

PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 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 \$[768] All but \$[192] a day All but \$[384] a day \$0 \$0	\$[768] (Part A deductible) \$[192] a day \$[384] 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 100 th 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 E

MEDICARE (PART B)—MEDICAL SERVICES—PER BENEFIT PERIOD

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

PARTS A & B

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

(continued)

PLAN E

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 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
*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*.

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [\$1530] deductible. Benefits from the high deductible plan F 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 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 90 th 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 101 st 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 coinsur- ance for out-patient drugs and inpatient respite care	\$0	Balance

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

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

**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [\$1530] deductible. Benefits from the high deductible plan F 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 foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$1530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$1530 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved amounts*	\$0	\$100 (Part B deductible	\$0
Remainder of Medicare Approved amounts	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	\$100 (Part B deductible	\$0
Remainder of Medicare Approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F**PARTS A & B**

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$1530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$1530 DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$100 of Medicare approved Amounts*	\$0	\$100 (Part B deductible)	\$0
Remainder of Medicare approved Amounts	80%	20%	\$0

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	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 life-time maximum

+-PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 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 \$[768] All but \$[192] a day All but \$[384] a day \$0 \$0	\$[768] (Part A deductible) \$[192] a day \$[384] 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 G

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

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

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

(continued)

PLAN G
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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 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 H

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

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

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

PARTS A & B

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

(continued)

PLAN H

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 Remainder of charges	\$0 \$0	\$0 80% to a lifetime max- imum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
BASIC OUTPATIENT PRE- SCRIPTION DRUGS—NOT COVERED BY MEDICARE First \$250 each calendar year Next \$2,500 each calendar year Over \$2,500 each calendar year	\$0 \$0 \$0	\$0 50%—\$1,250 calendar year maximum benefit \$0	\$250 50% All costs

PLAN I

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 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*			
Remainder of Medicare Approved Amounts	\$0	\$0	\$100 (Part B deductible)
Part B Excess Charges (Above Medicare Approved Amounts)	Generally 80%	Generally 20%	\$0
	\$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*	\$0	\$100 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	Generally 80% \$0	Generally 20% 100%	\$0 \$0
BLOOD First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$1530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$1530 DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
HOME HEALTH CARE (cont'd) 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	

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

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

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

³ Includes Modal Loadings and Fees 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"

MAY 30 2003

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

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

11.	Adjustment to Incurred Claims for Credibility Ratio 3 = Ratio 2 + Tolerance	
-----	--	--

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.
If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims [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 _____

(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 _____

(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
Total:			(k):		(l):		(m):		(n):	

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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.]

<p>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 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.]

<p>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 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.]

<p>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 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.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</p>

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.]

<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 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.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</p>

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>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.]

<p>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 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.]

<p>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 under this policy.

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

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

- hospitalization
- physician services
- other approved items and services

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

Before You Buy This Insurance

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

[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.]

<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. Medicare generally pays for most or all of these expenses.

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

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

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

[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.]

<p>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 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>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</p>
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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>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</p>
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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.]

<p>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 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.

D.C. OFFICE OF PERSONNEL**NOTICE OF FINAL RULEMAKING**

The Director, D.C. Office of Personnel, with the concurrence of the City Administrator, pursuant to Mayor's Order 2000-83, dated May 30, 2000, and in accordance with §§ 1051 through 1063 of the District of Columbia Government Comprehensive Merit Personnel Act of 1978, effective March 3, 1979, as amended (D.C. Official Code § 1-610.51 *et seq.* (2001)), hereby gives notice that final rulemaking action was taken to adopt the following rules. These rules amend Chapter 10, *D.C. Personnel Regulations*, Executive Service, to include language referencing the new domicile requirement applicable to appointees to the Executive Service and provide that a person serving in an acting or interim capacity shall become subject to the domicile requirement upon confirmation by the Council and promulgation of the Mayor's Order or personnel action appointing him or her to the Executive Service position; implement the provisions of the Executive Service Pay Plan; delete the dollar amount specified in the chapter for the payment of temporary housing allowances and relocation expenses, or both; add a new § 1004, Performance Contract; clarify the provisions regarding payment of performance incentives and specify that Executive Service employees shall not be eligible to receive monetary awards pursuant to Chapter 19, *D.C. Personnel Regulations*, Incentive Awards; renumber §§ 1004 through 1009 as §§ 1005 through 1010, respectively; and update the citations to the D.C. Official Code throughout the chapter. No comments were received under the notice of proposed rulemaking published at 50 DCR 2872 (April 11, 2003). Final rulemaking action was taken on May 19, 2003.

CHAPTER 10**EXECUTIVE SERVICE**

Section 1000.4 is amended to read as follows; a new § 1000.5 is added to read as follows; § 1000.5 is renumbered as § 1000.6 and amended to read as follows; and new §§ 1000.7 and 1000.8 are added to read as follows:

- 1000.4 Except in the case of an individual who meets the following criteria, any person who accepts appointment or is hired to fill a position in the Executive Service on or after October 1, 2002 shall become a domiciliary of the District of Columbia within one hundred eighty (180) days of the effective date of appointment and shall maintain District of Columbia domicile for the duration of appointment:
- (a) Any person who was an employee of the District of Columbia government on December 31, 1979, and who is still employed by the District of Columbia government without having had a break in service of one (1) workday or more since that date; or

- (b) Pursuant to the provisions of § 7 of the Saint Elizabeths Hospital and District of Columbia Mental Health Services Act, approved November 8, 1984 (P.L. 98-621; 98 Stat. 3376; 24 U.S.C. § 225e(b)), any former employee of the U.S. Department of Health and Human Services at St. Elizabeths Hospital who accepted employment with the District government without a break in service effective October 1, 1987, and who has not had a break in service since that date.

- 1000.5 Except as provided in § 1000.4(a) and (b), any employee in the Executive Service who was hired prior to October 1, 2002, and who was required to be or become a bona fide resident of the District of Columbia within one hundred eighty (180) days of appointment and maintain such residency for the duration of appointment or forfeit employment shall continue to be bound by the residency requirement that was in effect before October 1, 2002.
- 1000.6 Failure to become a domiciliary of the District of Columbia within the required period of time and to maintain District of Columbia domicile pursuant to this section shall result in forfeiture of employment.
- 1000.7 Notwithstanding the provisions of §§ 1000.4 through 1000.6, a person nominated to serve in an acting or interim capacity in the Executive Service shall not become subject to the domicile requirement until after confirmation by the Council and promulgation of a Mayor's Order or a personnel action appointing him or her to the Executive Service position. Specifically, the person shall become a domiciliary of the District of Columbia within one hundred eighty (180) days from the date specified in the Mayor's Order as the date of appointment, or from the effective date of the personnel action processed after Council confirmation to appoint him or her to the position, whichever action occurs first.
- 1000.8 The Director of Personnel shall inform each employee subject to the provisions of § 1000.7, in writing, of the exact date by which he or she shall meet the domicile requirement.

Previously "Reserved" § 1001 is added to read as follows:

1001 EXECUTIVE SERVICE PAY PLAN

- 1001.1 The Executive Service Pay Schedule ("DX Schedule") is divided into five (5) pay levels and is the basic pay schedule for positions in the Executive Service.
- 1001.2 The Director of Personnel shall provide relevant criteria for consideration by the Mayor in designating the appropriate pay level within the DX Schedule for each position in the Executive Service. Criteria shall include, but not be limited to, the following:
- (a) Agency budget characteristics;

- (b) Agency workforce characteristics;
- (c) Complexity of agency mission and functions; and
- (d) Desired qualifications for, or the impact of the person on, the position.

- 1001.3 A person appointed to a position in the Executive Service shall be appointed at the pay level on the DX Schedule designated for that position, and shall receive a salary set at any amount within the salary range that the Mayor determines to be appropriate.
- 1001.4 The Mayor, at his or her sole discretion, may change the salary of any person holding an appointment in the Executive Service at any time to any other salary within the salary range for the level occupied.
- 1001.5 The salary of an Executive Service employee who is temporarily assigned to a position at a higher or lower level in the DX Schedule shall be set, at the discretion of the Mayor, at any salary within the salary range of the level to which the employee is temporarily assigned or at a salary within the salary range of the level of the employee's regular Executive Service position.
- 1001.6 A person paid from the DX Schedule shall not be entitled to premium pay.
- 1001.7 A person holding an appointment in the Executive Service on the effective date of this section shall continue to be paid his or her existing salary until the Mayor effects a personnel action establishing a salary within the salary range for the designated level of the position on the DX Schedule.
- 1001.8 The Director of Personnel shall publish procedures to implement this section, including the level designated by the Mayor for each Executive Service position.

Subsection 1003.4 is amended to read as follows:

- 1003.4 Payment of expenses under §§ 1003.2 and 1003.3 may only be made after the selectee or appointee signs a notarized agreement to remain in the District government service for twelve (12) months after his or her appointment, unless separated for reasons beyond his or her control that are acceptable to the Mayor.

A new § 1004 is added to read as follows:

1004 PERFORMANCE CONTRACT

- 1004.1 The Mayor shall set performance expectations and goals for each subordinate agency head in a written annual performance contract. The performance contract shall outline agency-specific and operational goals, with a corresponding timeline for accomplishment of each goal. Both the Mayor and the subordinate agency head shall sign the annual performance contract.

- 1004.2 Each subordinate agency head shall be evaluated on an annual basis on the achievement of the performance expectations and goals in the performance contract for that year.
- 1004.3 The performance rating period for each subordinate agency head shall be from the beginning of each fiscal year to the end of the fiscal year.

Section 1004 is renumbered as § 1005 and amended to read as follows:

1005 PERFORMANCE INCENTIVES

- 1005.1 The Mayor may authorize performance incentives for exceptional service by a subordinate agency head.
- 1005.2 A performance incentive may be paid once in any fifty-two-week (52-week) period and only when the agency head is subject to an annual performance contract that clearly identifies measurable goals and outcomes and the agency head has exceeded contractual expectations in the year for which the incentive is to be paid.
- 1005.3 A performance incentive shall not be paid unless the agency head has served in the position for a continuous fifty-two-week (52-week) period prior to the granting of the performance incentive.
- 1005.4 The amount of a performance incentive shall be determined by the Mayor and shall not exceed ten percent (10%) of the employee's rate of basic pay in any year.
- 1005.5 A performance incentive pursuant to this section shall be approved in accordance with Chapter 19 of these regulations.
- 1005.6 An agency head shall not be eligible to receive monetary awards pursuant to Chapter 19 of these regulations.

Section 1005 is renumbered as § 1006; renumbered § 1006.3 is amended to update the citation to the chapter therein; and renumbered § 1006.4(b) is amended to update the citation to the D.C. Official Code:

- 1006.3 Separation pay, if authorized pursuant to § 1006.1, shall be provided at the time of separation from the District government as a lump-sum, one-time payment, subject only to the withholdings of federal, District of Columbia, and State income taxes, and social security taxes, if applicable.
- 1006.4 (b) Is eligible to receive an annuity under any retirement program for employees of the District government, excluding the District retirement benefit program under D.C. Official Code § 1-626.05 (2001).

Section 1006 is renumbered as § 1007; renumbered §§ 1007.4, 1007.11, 1007.12, 1007.13, and 1007.15 are amended to update the citations to the chapter therein; and renumbered §§ 1007.17 and 1007.18 are amended to update the citations to the D.C. Official Code:

- 1007.4 Except as provided in § 1007.5, each full biweekly pay period represents one (1) workday of accrued universal leave.
- 1007.11 Payment for leave upon separation from the Executive Service as provided in § 1007.10 shall be at the employee's rate of pay at the time of separation.
- 1007.12 Except as provided in § 1007.14, each employee in the Executive Service on January 2, 1999 shall have his or her accrued annual leave balance, up to a maximum of two hundred forty (240) hours, transferred to an annual leave escrow account for use at the discretion of the employee until exhausted.
- 1007.13 The employee shall be given a lump-sum payment for any annual leave in excess of the leave transferred pursuant to § 1007.12, payable at the rate of pay in effect on the last day of the last pay period of the 1998 leave year.
- 1007.15 The employee shall be given a lump-sum payment for any annual leave in excess of the leave transferred pursuant to § 1007.14, payable at the rate of pay in effect immediately before his or her appointment to the Executive Service.
- 1007.17 Sick leave credit of an Executive Service employee that was accrued under D.C. Official Code § 1-612.03(j) ((2001)) shall be held in a sick leave escrow account and may be used at the discretion of the employee until exhausted.
- 1007.18 Any balance remaining in a sick leave escrow account at the time of retirement of an Executive Service employee under the U.S. Civil Service Retirement System (Chapter 83 of Title 5 of the U.S. Code) or the Police and Fire Retirement System (D.C. Official Code § 5-701 *et seq.* (2001)) shall be available for use as additional service credit under the provisions of the applicable retirement system.

Reserved §§ 1007 through 1009 are renumbered as §§ 1008 through 1010, respectively.

Section 1099 is amended to update the citation to the D.C. Official Code in the definition of the terms "Executive Service" and "subordinate agency;" and to correct the citations to the chapter in the definition of the terms "Pre-employment travel expenses," "Relocation expenses," and "Temporary housing allowance:"

Executive Service – except as modified by § 1007.1 for purposes of § 1007, any subordinate agency head position under the administrative control of the Mayor, to which the Mayor is authorized to appoint executives in accordance with D.C. Official Code § 1-610.51 *et seq.* (2001).

Pre-employment travel expenses – expenses allowed for an individual pursuant to § 1003.1, which may include such items as hotel accommodations, travel (commercial carrier, privately owned vehicle, *etc.*), and a per diem allowance.

Relocation expenses – expenses allowed for an individual and his or her immediate family pursuant to § 1003.2, which may include such items as transportation of family, transportation of household goods and expenses related thereto, temporary storage expenses, relocation services company, property management services, and a per diem allowance.

Subordinate agency – the meaning provided in D.C. Official Code § 1-603.01(17) (2002).

Temporary housing allowance – subsistence expenses incurred by an individual and his or her immediate family while occupying lodging obtained for the purpose of temporary occupancy when authorized pursuant to § 1003.3.

DISTRICT OF COLUMBIA DEPARTMENT OF TRANSPORTATION

NOTICE OF FINAL RULEMAKING

DOCKET NUMBER 02-55-TS

The Director of the Department of Transportation, pursuant to the authority in sections 3, 5(3), and 6 of the Department of Transportation Establishment Act of 2002, effective May 21, 2002 (D.C. Law 14-137; D.C. Official Code §§ 50-921.02, 50-921.04(3) and 50-921.05), and sections 6(a)(1), 6(a)(6) and 6(b) of the District of Columbia Traffic Act, approved March 3, 1925 (43 Stat. 1121; D.C. Official Code § 50-2201.03(a)(1), (a)(6) and (b)), hereby gives notice of the adoption of the following rulemaking which amends the Vehicle and Traffic Regulations (18 DCMR). Final action to adopt this rulemaking was taken on November 8, 2002. No comments have been received and no changes have been made to the text of the proposal as published on November 22, 2002 at 49 DCR 10627. This final rulemaking will be effective when published in the D.C. Register.

Title 18 DCMR, Section 4004, ONE WAY STREETS, Subsection 4004.1 (b) Northwest Section, is amended by deleting the following from the list of locations where traffic is restricted to one direction of travel:

“Constitution Avenue, N.E., from 3rd Street to North Carolina Avenue, for westbound traffic only, 7:00-9:30 A.M., Except Saturdays, Sundays and Holidays”.

and by substituting the following:

“Constitution Avenue, N.E., from 3rd Street to North Carolina Avenue, for westbound traffic only, 6:45-9:30 A.M., Except Saturdays, Sundays and Holidays”.

DISTRICT OF COLUMBIA DEPARTMENT OF TRANSPORTATION

NOTICE OF FINAL RULEMAKING

DOCKET NUMBER 02-56-TS

The Director of the Department of Transportation, pursuant to the authority in sections 3, 5(3), and 6 of the Department of Transportation Establishment Act of 2002, effective May 21, 2002 (D.C. Law 14-137; D.C. Official Code §§ 50-921.02, 50-921.04(3) and 50-921.05), and sections 6(a)(1), 6(a)(6) and 6(b) of the District of Columbia Traffic Act, approved March 3, 1925 (43 Stat. 1121; D.C. Official Code § 50-2201.03(a)(1), (a)(6) and (b)), hereby gives notice of the adoption of the following rulemaking which amends the Vehicle and Traffic Regulations (18 DCMR). Final action to adopt this rulemaking was taken on May 6, 2003. No comments have been received and no changes have been made to the text of the proposal as published on November 22, 2002 at 49 DCR 10628. This final rulemaking will be effective when published in the D.C. Register.

Title 18 DCMR, Section 4002, TRUCK RESTRICTIONS, Subsection 4002.1 (a) Northwest Section, is amended by adding the following to the list of locations where TRUCK RESTRICTIONS are installed:

“21st Street, N.W., between Massachusetts and Florida Avenues”.

DISTRICT OF COLUMBIA DEPARTMENT OF TRANSPORTATION

NOTICE OF FINAL RULEMAKING

DOCKET NUMBER 02-58-TS

The Director of the Department of Transportation, pursuant to the authority in sections 3, 5(3), and 6 of the Department of Transportation Establishment Act of 2002, effective May 21, 2002 (D.C. Law 14-137; D.C. Official Code §§ 50-921.02, 50-921.04(3) and 50-921.05), and sections 6(a)(1), 6(a)(6) and 6(b) of the District of Columbia Traffic Act, approved March 3, 1925 (43 Stat. 1121; D.C. Official Code § 50-2201.03(a)(1), (a)(6) and (b)), hereby gives notice of the adoption of the following rulemaking which amends the Vehicle and Traffic Regulations (18 DCMR). Final action to adopt this rulemaking was taken on May 4, 2003. No comments have been received and no changes have been made to the text of the proposal as published on November 22, 2002 at 49 DCR 10629. This final rulemaking will be effective when published in the D.C. Register.

Title 18 DCMR, Section 4015, "NO LEFT TURN" RESTRICTIONS, § 4015.4, (a) Northwest Section, is amended by deleting the following from the list of locations where Left Turns are restricted between 4-6:30 PM, Monday-Friday:

"Eastbound Constitution Avenue, N.W., so as to proceed northbound on 21st Street".

Title 18 DCMR, Section 4015, "NO LEFT TURN" RESTRICTIONS, § 4015.7, (a) Northwest Section, is amended by deleting the following from the list of locations where Left Turns are restricted between 4-6:30 PM, Monday-Friday, except buses:

"Eastbound Constitution Avenue, N.W., so as to proceed northbound on 21st Street".

DISTRICT OF COLUMBIA DEPARTMENT OF TRANSPORTATION

NOTICE OF FINAL RULEMAKING

DOCKET NUMBER 03-17-TS

The Director of the Department of Transportation, pursuant to the authority in sections 3, 5(3), and 6 of the Department of Transportation Establishment Act of 2002, effective May 21, 2002 (D.C. Law 14-137; D.C. Official Code §§ 50-921.02, 50-921.04(3) and 50-921.05), and §§ 6(a)(1), 6(a)(6) and 6(b) of the District of Columbia Traffic Act, approved March 3, 1925 (43 Stat. 1121; D.C. Official Code § 50-2201.03(a)(1), (a)(6) and (b)), hereby gives notice of the adoption of the following rulemaking which amends chapter 40 of the Vehicles and Traffic Regulations (18 DCMR). Final action to adopt this rulemaking was taken on May 4, 2003. No comments have been received and no changes have been made to the text of the proposal as published on April 4, 2003 at 50 DCR 2612. This final rulemaking will be effective when published in the D.C. Register.

Title 18 DCMR, § 4011, SPEED LIMIT, § 4011.2.Northeast Section (b), is amended by deleting the following from the locations where the speed limit is THIRTY MILES PER HOUR (30MPH):

“On Bladensburg Road, N.E. from Mount Olivet Road to New York Avenue”.