RULES AND REGULATIONS

Title 31—INSURANCE

INSURANCE DEPARTMENT

[31 PA. CODE CH. 89]

Medicare Supplement Insurance Minimum Standards

The Insurance Department (Department) amends §§ 89.772, 89.774, 89.776—89.778, 89.780, 89.781, 89.783, 89.788 and 89.790, and Appendix I, to read as set forth in Annex A. Sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412) provide the Insurance Commissioner (Commissioner) with the authority and duty to promulgate regulations governing the enforcement of the laws relating to insurance. The amendments will bring the Department's regulations for the approval of Medicare supplement policies into compliance with the Federal statutory requirements of section 1882 of the Social Security Act (42 U.S.C.A. § 1395ss) and the Balanced Budget Act of 1997 (Pub. L. No. 105-33).

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

The changes indicated to Subchapter K (relating to Medicare supplement insurance minimum standards) are Federally mandated under recent Federal legislation, the Balanced Budget Act of 1997 (Pub. L. No. 105-33, 111 Stat. 251), with an effective date of July 1, 1998. The Federal law also establishes a timetable under which these changes are to be implemented by the states if they are to remain in compliance with the Federal requirements and maintain regulatory authority in this area. To comply with Federal statutory minimum requirements for Medicare supplement policies, as mandated by section 4031 of the Balanced Budget Act of 1997, the Commissioner finds that the proposed rulemaking procedures in sections 201 and 202 of the CDL (45 P. S. §§ 1201 and 1202) are impracticable and unnecessary in this situation, and that the proposed rulemaking may be properly omitted under section 204(3) of the CDL.

Purpose

Subchapter K was initially promulgated to establish minimum standards for Medicare supplement insurance policies. Standardization of policies was Federally required under the Omnibus Budget Reconciliation Act of 1990. The Department currently seeks to modify Subchapter K to meet the new Federal mandates for Medicare supplement policies as required under the Balanced Budget Act of 1997. The Federal law mandates that many of its requirements become effective not later than July 1, 1998, including the new open enrollment and guarantee issue requirements contained in §§ 89.778 and 89.790 (relating to open enrollment; and guaranteed issue for eligible persons).

These amendments are necessary to maintain the Commonwealth's compliance with Federal requirements, which will ensure that the Commonwealth retains enforcement authority over these new requirements. These standards will be implemented through Federal preemption if the Commonwealth does not implement these changes through State regulation. The Federal legislation establishes that states which adopt the language of the NAIC Medicare Supplement model regulation which has been revised to address the Federal changes will be considered to be in compliance with the Federal requirements.

These amendments will protect the rights of the consumers in this Commonwealth purchasing Medicare supplement policies. In addition to the mandated changes, the Department has clarified and revised language to improve the readability of the regulations. The clarifications and revisions are not substantive in nature.

Explanation of Regulatory Requirements

Section 89.772 (relating to definitions) has been modified to include additional definitions necessary to implement the new Federal requirements under the Balanced Budget Act of 1997. The added definitions are based on the revised NAIC Medicare Supplement model regulation which, as indicated above, has been endorsed and supported by the Federal government.

Section 89.774 (relating to policy provisions) was previously inappropriately captioned. The Department seeks to correctly caption this provision to reflect the topic covered as "Exclusions and Limitations." This section does not establish policy provisions; it explains acceptable policy exclusions and limitations.

Section 89.776 (relating to benefit standards) has been modified. Section 89.776 (3)(iv) and (v) has been revised to reflect that the Health Care Practitioners Medicare Fee Control Act (35 P. S. §§ 449.31—449.36), limits the amount that providers may bill Medicare patients.

Section 89.777(e)(7) and (12) (relating to standard Medicare supplement benefit plans) has been added to reflect the requirements for high deductible policies which can now be offered under Plans F and J. The new language is based on the revised NAIC Medicare Supplement model regulation.

Section 89.778(a) (relating to open enrollment) has been modified to clarify that insurance companies are not required to offer coverage in group plans to persons who are not members of the insured group.

Section 89.778(b) has been added to provide for the counting of "prior creditable coverage" which will be applied against any preexisting condition exclusion period otherwise applicable to individuals. The application of this concept, new to the Medicare supplement arena, reduces or eliminates the preexisting condition exclusion periods which individuals are otherwise subject to serving. This is similar in concept to the counting of creditable coverage and the reduction/elimination of preexisting condition exclusions in the commercial health insurance market under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191, 110 Stat. 1936) (HIPAA), which has been adopted and codified in this Commonwealth as the Pennsylvania Health Care Insurance Portability Act (40 P. S. §§ 1302.1—1302.7). This new language is also based on the revised NAIC Medicare Supplement model regulation.

Section 89.780(c)(1)(i) (relating to the loss ratio standards) was revised to clarify how the Department inter-

prets this section. The revision does not alter how the Department has been interpreting this section since the effective date of this regulation.

Section 89.781(c)(2) (relating to filing and approval) was amended to define what constitutes a "type" for purposes of offering more than one policy for the same standard Medicare benefit plan. This amendment does not alter how the Department has been interpreting this section since the effective date of this regulation.

Section 89.783 (relating to required disclosure provisions) was amended to add clarifying language to subsection (a)(4) and (6). Additionally, the Department seeks to clarify the disclosure requirement under subsections (b) and (c). This change is intended to eliminate unnecessary filings and to reduce any administrative burden imposed by these filings on issuers.

Section 89.783 has also been modified for all plan specific Medicare supplement coverage charts for Plans A—J to reflect the current Federal Medicare deductibles. These deductibles are variables, which are changed by the Federal government on a regular basis. The deductibles can be updated by the Federal government and implemented by issuers in accordance with § 89.783(c)(4) (relating to required disclosure provisions) without modifications to this regulation. The Outline of Medicare supplement coverage—Cover Page, and Plans F and J, have been modified to add the new high deductible policies now allowed in Plans F and J. This new language is based on the revised NAIC Medicare Supplement model regulation.

The preventive benefits reflected in the charts for Plans E and J have been modified to address the new preventive benefits now covered under Medicare. This new language is based on the revised NAIC Medicare Supplement model regulation.

Section 89.788(a) (relating to reporting of multiple policies) is being modified to clarify the intended purpose and issuer responsibility.

Section 89.790 (relating to guaranteed issue for eligible persons) has been added to meet new Federal requirements under the Balanced Budget Act of 1997. The Balanced Budget Act created Medicare Part C known as "Medicare+Choices." Medicare+Choices is designed to expand the coverage options for Medicare eligibles beyond traditional Medicare and the current coordinated care programs such as HMOs. The new coverage options in Medicare+Choices include HMOs, PPOs, Provider Sponsored Organizations, Medical Savings Accounts and private fee-for-service plans.

The Federal legislation allows individuals who have been enrolled in a Medicare+Choice product or a Medicare supplement policy to select or return to a Medicare supplement policy on a guaranteed issue basis under certain circumstances. These circumstances include the termination of the Medicare+Choice plan's certification to participate in the Medicare+Choice program, the subscriber moving out of the Medicare+Choice plan's service area and the bankruptcy or insolvency of a Medicare supplement issuer. This new language meets the Federal requirements and is based on the revised NAIC Medicare Supplement model regulation.

Appendix I (relating to disclosure statements) has been revised to incorporate changes made necessary by the Balanced Budget Act of 1997. The revised disclosure statements are based on the revised NAIC Medicare Supplement model regulation.

Fiscal Impact

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

The insurance industry will likely incur additional costs associated with complying with the new Federal requirements. Specifically, the open enrollment and guaranteed eligibility provisions may increase the utilization of services and therefore, the cost of policies. There is currently no way to assess these potential costs.

Issuers should see a potential cost reduction in the changed requirements for disclosure notices. However, this factor may be balanced against increased costs due to the new Federal open enrollment and guaranteed issue requirements.

Effectiveness/Sunset Date

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

Paperwork

Adoption of these amendments will require additional paperwork for insurance carriers' product development areas to implement the new Federal changes. The new notice requirements should, however, bring about decreased paperwork. Paperwork requirements for the Department will likely not change drastically.

Persons Regulated

These amendments apply to all insurance companies who issue Medicare supplement products in this Commonwealth.

Contact Person

The person to contact for information on the amendments is Peter J. Salvatore, Regulatory Coordinator, 1326 Strawberry Square, Harrisburg, PA 17120, (717) 787-4429.

Regulatory Review

Under section 5.1(c) of the Regulatory Review Act (71 P. S. § 745.5a(c)), on November 10, 1998, the Department submitted a copy of the amendments with the proposed rulemaking omitted to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Committee on Insurance and the Senate Committee on Banking and Insurance. On the same date, the amendments were submitted to the Office of Attorney General for review and approval under the Commonwealth Attorneys Act (71 P. S. §§ 732-101—732-506).

In accordance with section 5.1(d) of the Regulatory Review Act, the amendments were deemed approved by the Senate Banking and Insurance Committee and by the House Insurance Committee on November 30, 1998. IRRC met on December 10, 1998, and approved the amendments.

Findings

The Insurance Commissioner finds that:

(a) There is good cause to amend Chapter 89, Subchapter K, effective upon publication with the proposed rulemaking omitted. Deferral of the effective date of these amendments would be impractical and not serve the public interest. Under section 204(3) of the CDL, there is no purpose to be served by deferring the effective date. An immediate effective date will best serve the public interest by ensuring the Commonwealth's compli-

ance with the new Federal requirements and retention of enforcement authority over all aspects of Medicare supplement policies.

(b) There is good cause to forego public notice of the intention to amend Chapter 89, Subchapter K, because prior notice of the amendments under the circumstances is unnecessary and impractical (45 P. S. § 1204(3)) for the following reasons:

(1) The changes mandated by Federal law will go into effect with or without Commonwealth regulatory action.

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

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

Order

The Insurance Commissioner, acting under the authority orders that:

(a) The regulations of the Department, 31 Pa. Code Chapter 89, are amended by amending §§ 89.772, 89.774, 89.776—89.778, 89.780, 89.781, 89.783 and 89.788 and by adding § 89.790 to read as set forth in Annex A, with ellipses referring to the existing text of the regulations.

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

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

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

M. DIANE KOKEN,
Insurance Commissioner

(*Editor's Note:* For the text of the order of the Independent Regulatory Review Commission relating to this document, see 28 Pa.B. 6359 (December 26, 1998).)

Fiscal Note: 11-177. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 31. INSURANCE

PART IV. LIFE INSURANCE

CHAPTER 89. APPROVAL OF LIFE, ACCIDENT AND HEALTH INSURANCE

Subchapter K. MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

§ 89.772. Definitions.

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

Applicant—

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

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

Bankruptcy—The condition under which a Medicare+Choice plan that is not an issuer has filed, or has had filed against it, a petition or other action seeking a declaration of bankruptcy under the provisions of the United States Bankruptcy Code (11 U.S.C.) and has ceased doing business in this Commonwealth.

Certificate—A certificate delivered or issued for delivery in this Commonwealth under a group Medicare supplement policy.

Certificate form—The form on which the certificate is delivered or issued for delivery by the issuer.

Commissioner—The Insurance Commissioner of the Commonwealth.

Continuous period of creditable coverage—The period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

Creditable coverage—The definition contained in the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191, 110 Stat. 1936), as adopted by the Commonwealth under the Pennsylvania Health Care Insurance Portability Act (40 P. S. §§ 1302.1—1302.7), is incorporated herein by reference.

Employe welfare benefit plan—A plan, fund or program of employe benefits as defined in section 3 of the Employee Retirement Income Security Act or ERISA (29 U.S.C.A. § 1002).

HHS Secretary—The Secretary of the United States Department of Health and Human Services.

Insolvency—The condition under which an issuer, licensed to transact business in this Commonwealth by the Commissioner, has had a final order of liquidation entered against it, or a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

Issuer—The term includes insurance companies, fraternal benefit societies and nonprofit corporations subject to 40 Pa.C.S. Chapters 61 and 63 (relating to hospital plan corporations; and professional health services plan corporations) and other entities delivering or issuing for delivery Medicare supplement policies or certificates in this Commonwealth.

Medicare—The program established by the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 (42 U.S.C.A. §§ 1395—1395b-4) as then constituted or later amended.

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

(i) Coordinated care plans which provide health care services, including health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations and preferred provider organization plan.

(ii) Medicare medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account.

(iii) Medicare+Choice private fee-for-service plans.

Medicare supplement policy—A group or individual policy of insurance or a subscriber contract other than a policy issued under a contract under section 1876 of the Social Security Act (42 U.S.C.A. §§ 1395—139mm or a policy issued under a demonstration project specified in section 1882 of the SSA (42 U.S.C.A. § 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—The form on which the policy is delivered or issued for delivery by the issuer.

§ 89.774. Exclusions and limitations.

(a) Except for permitted preexisting condition clauses as described in §§ 89.775(1)(i) and 89.776(1)(i) (relating to minimum benefit standards for policies or certificates issued for delivery prior to July 30, 1992; and benefits standards for policies or certificates issued or delivered on or after July 30, 1992), a policy or certificate may not be advertised, solicited or issued for delivery in this Commonwealth as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(b) A Medicare supplement policy or certificate may not use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

(c) A Medicare supplement policy or certificate in force in this Commonwealth may not contain benefits which duplicate benefits provided by Medicare.

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

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

* * * * *

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

(i) *Medicare Part A deductible.* Coverage for the Medicare Part A inpatient hospital deductible amount per benefit period.

(ii) *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 posthospital skilled nursing facility care eligible under Medicare Part A.

(iii) *Medicare Part B deductible.* Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(iv) *Eighty percent of the Medicare Part B excess charges.* Coverage for 80% of the difference between the actual Medicare Part B charges as billed, not to exceed a charge limitation established by the Medicare Program, State Law, including, but not limited, to the Health Care Practitioner Medicare Fee Control Act (35 P. S. §§ 449.31—449.36), and the Medicare-approved Part B charge.

(v) *Medicare Part B excess charges.* One hundred percent of the Medicare Part B excess charges: coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed a charge limitation established by the Medicare Program, State law, including, but not limited to, the Health Care Practitioner Medicare Fee Control Act and the Medicare-approved Part B charge.

* * * * *

§ 89.777. Standard Medicare supplement benefit plans.

(a) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic core benefits, as defined in § 89.776(2) (relating to benefits standards for policies or certificates issued for delivery on or after July 30, 1992). An issuer shall also offer a policy or certificate to prospective insureds meeting the Plan B benefit plan.

(b) Groups, packages or combinations of Medicare supplement benefits other than those listed in this section may be offered for sale in this Commonwealth except as may be permitted in § 89.776(3)(xi).

(c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans A, B, C, D, E, F, G, H, I and J listed in this section and conform to the definitions in § 89.773 (relating to policy definitions and terms). Each benefit shall be structured in accordance with the format in §§ 89.776(2) and (3) and list the benefits in the order shown in this section. For purposes of this section, "structure, language and format" means style, arrangement and overall content of a benefit.

(d) An issuer may use, in addition to the benefit plan designations required in subsection (c), other designations to the extent permitted by law.

(e) The make-up of benefit plans shall be as follows:

(1) Standardized Medicare supplement benefit Plan A shall be limited to the basic (core) benefits common to all benefit plans, as defined in § 89.776(2).

(2) Standardized Medicare supplement benefit Plan B shall include only the following: the core benefit as defined in § 89.776(2), plus the Medicare Part A Deductible as defined in § 89.776(3)(i).

(3) Standardized Medicare supplement benefit Plan C shall include only the following: the core benefit as defined in § 89.776(2), plus 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 § 89.776(3)(i)—(iii) and (viii).

(4) Standardized Medicare supplement benefit Plan D shall include only the following: the core benefit (as defined in § 89.776(2)), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in § 89.776(3)(i), (ii), (viii) and (x).

(5) Standardized Medicare supplement benefit Plan E shall include only the following: the core benefit as defined in § 89.776(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in § 89.776(3)(i), (ii), (viii) and (ix).

(6) Standardized Medicare supplement benefit Plan F shall consist of only the following: the core benefit as defined in § 89.776(2), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% of the Medicare Part B excess charges

and medically necessary emergency care in a foreign country as defined in § 89.776(3)(i)—(iii), (v) and (viii).

(7) Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 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 § 89.776(2), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% of the Medicare Part B excess charges and medically necessary emergency care in a foreign country as defined in § 89.776(3)(i)—(iii), (v) and (viii) respectively. 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 $1,500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the HHS Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(8) Standardized Medicare supplemental benefit Plan G shall include only the following: the core benefit as defined in § 89.776(2), plus the Medicare Part A deductible, skilled nursing facility care, 80% of the Medicare Part B excess charges, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in § 89.776(3)(i), (ii), (iv), (viii) and (x).

(9) Standardized Medicare supplement benefit Plan H shall consist of only the following: the core benefit as defined in § 89.776(2), plus 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 § 89.776(3)(i), (ii), (vi) and (viii).

(10) Standardized Medicare supplement benefit Plan I shall consist of only the following: the core benefit as defined in § 89.776(2), plus the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in § 89.776(3)(i), (ii), (v), (vi), (viii) and (x).

(11) Standardized Medicare supplement benefit Plan J shall consist of only the following: the core benefit as defined in § 89.776(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 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 § 89.776(3)(i)—(iii), (v) and (vii)—(x).

(12) 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 § 89.776(2) plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 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 § 89.776(3)(i)—(iii), (v) and (vii)—(x) 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 plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1,500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the HHS Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

§ 89.778. Open enrollment.

(a) An issuer may not deny or condition the issuance or effectiveness of a Medicare supplement policy or certificate available for sale in this Commonwealth, 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 6-month period beginning with the first day of the first month in which an individual enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to applicants who qualify under this subsection without regard to age. In the case of group policies, an issuer may condition issuance on whether an applicant is a member or is eligible for membership in the insured group.

(b) If an applicant qualifies under subsection (a) and submits an application during the time period referenced in subsection (a) and, as of the date of application, has had a continuous period of creditable coverage of at least 6 months, the issuer may not exclude benefits based on a preexisting condition.

(c) If the applicant qualifies under subsection (a) and submits an application during the time period referenced in subsection (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than 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 HHS Secretary shall specify the manner of the reduction under this subsection.

(d) Except as provided in § 89.789, subsection (a) will not be construed as preventing the exclusion of benefits under a policy, during the first 6 months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the 6 months before it became effective.

§ 89.780. Loss ratio standards and refund or credit of premium.

* * * * *

(c) *Annual filing of premium rates.* An issuer of Medicare supplement policies and certificates issued before, on or after July 30, 1992, in this Commonwealth 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 in accordance with the filing requirements and procedures prescribed by the Commissioner. 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. That demonstration shall exclude active life reserves. An expected 3rd-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less

than 3 years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare polices or certificates in this Commonwealth shall file with the Commissioner, in accordance with the applicable filing procedures of the Commonwealth:

(1) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Supporting documents as necessary to justify the adjustment shall accompany the filing.

(i) An issuer shall make premium adjustments as necessary to produce an expected loss ratio under the policy or certificate that will conform with minimum loss ratio standards for the Medicare supplement policies, and that will result in an expected loss ratio at least as great as that originally anticipated by the issuer for that policy or certificate. A premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described in this section may not be made with respect to a policy at any time other than upon its renewal date or anniversary date.

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§ 89.781. Filing and approval of policies and certificates and premium rates.

(a) *Approval of policy or certificate.* An issuer may not deliver or issue for delivery a policy or certificate to a resident of this Commonwealth, unless the policy form or certificate form has been filed with and approved by the Commissioner in accordance with filing requirements and procedures prescribed by the Commissioner.

(b) *Filing of rating schedule and supporting documentation.* An issuer may not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Commissioner in accordance with the filing requirements and procedures prescribed by the Commissioner.

(c) *Exceptions.*

(1) Except as provided in paragraph (2), an issuer may not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the Commissioner, up to three additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan. These additional forms may include one or more of the following three variations. Forms with only these variations will be regarded as new policy forms under each type:

(i) The inclusion of new or innovative benefits.

(ii) The addition of either direct response or agent marketing methods.

(iii) The addition of either guaranteed issue or underwritten coverage.

(3) For the purpose of this section, a "type" means an individual policy, a group policy, an individual Medicare Select Policy or a group Medicare Select Policy.

(d) *Availability of policy form.*

(1) Except as provided in clause (A), an issuer shall continue to make available for purchase any policy form or certificate form issued after July 30, 1992, that has been approved by the Commissioner. A policy form or certificate form may not be considered to be available for purchase, unless the issuer has actively offered it for sale in the previous 12 months.

(A) 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 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the Commissioner, the issuer may not offer for sale the policy form or certificate form in this Commonwealth.

(B) An issuer that discontinues the availability of a policy form or certificate form under clause (A) may 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 5 years after the issuer provides notice to the Commissioner of the discontinuance. The period of discontinuance may be reduced if the Commissioner determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this section.

(3) A change in the rating structure or methodology shall be considered a discontinuance under paragraph (1), unless the issuer complies with the following requirements:

(i) 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.

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

(e) *Combination of forms.*

(1) Except as provided in paragraph (2), 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 § 89.780 (relating to loss ratio standards and refund or credit of premium).

(2) Forms assumed under an assumption reinsurance agreement may not be combined with the experience of other forms for purposes of the refund or credit calculation.

§ 89.783. Required disclosure provisions.

(a) *General rules.*

* * * * *

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, these limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

* * * * *

(6) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person eligible for Medicare, shall provide to these applicants a Guide to Health Insurance for People with Medicare (Guide) in the form developed jointly by the National Association of Insurance Commissioners and the Health

Care Financing Administration and in a type size no smaller than 12 point type. Delivery of the Guide shall be made whether or not these policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this subchapter. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuers. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

* * * * *

(b) *Notice requirements.*

* * * * *

(1) As soon as practicable, but no later than 30 days prior to the annual effective date of Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the Commissioner. The notice shall:

(i) 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.

(ii) Inform each policyholder or certificateholder as to when a premium adjustment is to be made due to changes in Medicare.

* * * * *

(4) Once the Department has approved the form, a "Notice of Change" can be used to modify the deductible and co-payment amounts to reflect Medicare changes without submitting the notice for additional approval. Once the Department has approved the form, only format changes are required to be submitted for review.

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

* * * * *

(4) Once the Department has approved the format, an "Outline of Coverage" can be modified to have the deductible and co-payment requirements reflect Medicare changes, and the rate changes reflected, without submitting the Outline of Coverage for review. Only those forms containing a format change are required to be submitted for review.

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

* * * * *

[COMPANY NAME]
Outline of Medicare Supplement Coverage-Cover Page:

Benefit Plans _____ (insert letters of plans being offered)

Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan A & B.

Basic Benefits: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses).
Blood: First three pints of blood each year.

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

*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year [$1,500] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are [$1,500]. Out-of-pocket expenses for this deductible ar expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does not include, in plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.

PLAN A

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

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

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

PLAN A

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

PLAN B

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

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

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

PLAN B

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

PLAN C

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $760	$760 (Part A deductible)	$0
61st thru 90th day	All but $190 a day	$190 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $380 a day	$380 a day	$0
— Once lifetime reserve days are used:		100% of Medicare	
— Additional 365 days	$0	eligible expenses	$0
— Beyond the additional 365 days	$0	$0	All costs

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $95 a day	Up to $95 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN C

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

OTHER BENEFITS—COVERED BY MEDICARE

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

PLAN D

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

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

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

PLAN D

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	0	$0

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	$0	Actual charges to $40 a visit	Balance
— Benefit for each visit	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
— Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	$1,600	
— Calendar year maximum			

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN E

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

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

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

PLAN E

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES—			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 life-time maximum
PREVENTIVE MEDICARE CARE BENEFIT—NOT COVERED BY MEDICARE Some physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

PLAN F or HIGH DEDUCTIBLE PLAN F

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1,500] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$1,500]. 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 $1,500 DEDUCTIBLE,** PLAN PAYS*	*IN ADDITION TO $1,500 DEDUCTIBLE,** YOU PAY*
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $760	$760 (Part A deductible)	$0
61st thru 90th day	All but $190 a day	$190 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $380 a day	$380 a day	$0
— Once lifetime reserve days are used:		100% of Medicare	
— Additional 365 days	$0	eligible expenses	$0
— Beyond the additional 365 days	$0	$0	All costs

SERVICES	*MEDICARE PAYS*	*AFTER YOU PAY $1,500 DEDUCTIBLE,** PLAN PAYS*	*IN ADDITION TO $1,500 DEDUCTIBLE,** YOU PAY*
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $95 a day	Up to $95 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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 [$1,500] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$1,500]. 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 $1,500 DEDUCTIBLE,** PLAN PAYS*	*IN ADDITION TO $1,500 DEDUCTIBLE,** YOU PAY*
MEDICAL EXPENSES—			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric service)	20% (50% outpatient psychiatric service)	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	*MEDICARE PAYS*	*AFTER YOU PAY $1,500 DEDUCTIBLE,** PLAN PAYS*	*IN ADDITION TO $1,500 DEDUCTIBLE,** YOU PAY*
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 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 $760 All but $190 a day All but $380 a day $0 $0	 $760 (Part A deductible) $190 a day $380 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 $95 a day $0	 $0 Up to $95 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

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$0
Part B excess charges (Above Medicare approved amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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		Actual charges to $40 a visit	Balance
— Benefit for each visit	$0		
— Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
— Calendar year maximum	$0	$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

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

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 life-time maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs

PLAN I

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

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

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

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

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

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $100 of Medicare approved amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
— Benefit for each visit	$0	Actual charges to $40 a visit	Balance
— Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
— Calendar year maximum	$0	$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges*	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 life-time maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs

PLAN J or HIGH DEDUCTIBLE PLAN J

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
**This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [$1,500] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [$1,500]. 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 $1,500 DEDUCTIBLE,** PLAN PAYS*	*IN ADDITION TO $1,500 DEDUCTIBLE,** YOU PAY*
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $760	$760 (Part A deductible)	$0
61st thru 90th day	All but $190 a day	$190 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $380 a day	$380 a day	$0
— Once lifetime reserve days are used:		100% of Medicare eligible expenses	
— Additional 365 days	$0		$0
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $95 a day	Up to $95 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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 $[1,500] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [$1,500]. 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 $1,500 DEDUCTIBLE,** PLAN PAYS*	*IN ADDITION TO $1,500 DEDUCTIBLE,** YOU PAY*
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80% (50% outpatient psychiatric services)	20% (50% outpatient psychiatric services)	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50%—$3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All costs
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

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

* * * * *

§ 89.788. Reporting of multiple policies

(a) On or before March 1 of each year, an issuer shall report the following information for every individual resident of this Commonwealth for which the issuer has in force more than one Medicare supplement policy or certificate. This information must only be submitted for those issuers having insureds with more than one policy:

(1) The policy and certificate number.

(2) The date of issuance.

(b) The items in subsection (a) shall be grouped by individual policyholder.

§ 89.790. Guaranteed issue for eligible persons

(a) *Guaranteed issue.*

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

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

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

(ii) Discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care or medical condition.

(iii) Impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

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

(1) The individual is enrolled under an employe welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all supplemental Medicare health benefits to the individual; or the individual is enrolled under an employe welfare benefit plan that is primary to Medicare and the plan terminates, or the plan ceases to provide health benefits to the individual because the individual leaves the plan.

(2) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, and any of the following circumstances apply:

(i) The organization's or plan's certification has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(ii) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the HHS Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the Social Security Act (42 U.S.C.A. § 1395w-21(g)(3)(B)) (when the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856 of the Social Security Act (42 U.S.C.A. § 1395w-26), or the plan is terminated for all individuals within a residence area).

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

(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 the covered care in accordance with applicable quality standards.

(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.

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

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

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

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

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

(iv) An organization under a Medicare Select policy.

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because one of the following applies:

(i) The insolvency of the issuer or bankruptcy of the nonissuer organization or of other involuntary termination of coverage or enrollment under the policy.

(ii) The issuer of the policy substantially violated a material provision of the policy.

(iii) 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.

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

(6) The individual, upon first becoming eligible for benefits under Part A or enrolled in Part B of Medicare at age 65 or older, enrolls in a Medicare+Choice plan under Part C of Medicare, and disenrolls from the plan within 12 months after the effective date of enrollment.

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

(1) Subsection (b)(1)—(4) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C or F offered by an issuer.

(2) Subsection (b)(5) 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 (1).

(3) Subsection (b)(6) includes any Medicare supplement policy offered by an issuer.

(d) *Notification provisions.*

(1) At the time of an event described in subsection (b) 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 individuals of their rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (a). The notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in subsection (b) 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 individuals of their rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (a). The notice shall be communicated within 10 working days of the issuer receiving notification of disenrollment.

APPENDIX I

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.A. § 1395ss) prohibits the sale of health insurance policies (the term policy or policies includes certificates) that duplicate Medicare benefits unless it will pay benefits without regard to 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.

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 policies are 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 Social Security Act was amended in subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix I remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

(Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.)

Important Notice to Persons on Medicare

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Original disclosure statement for policies that provide benefits for specified limited services.)

Important Notice to Persons on Medicare

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

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

- hospitalization
- physician services
- other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

Important Notice to Persons on Medicare

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

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

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

Important Notice to Persons on Medicare

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

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

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

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

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

Important Notice to Persons on Medicare

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

Medicare generally pays for most or all of these expenses.

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

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

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

Important Notice to Persons on Medicare

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

Medicare generally pays for most or all of these expenses.

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

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

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

Important Notice to Persons on Medicare

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

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

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.)

Important Notice to Persons on Medicare

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- other approved items and services

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

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Alternative disclosure statement for policies that provide benefits for specified limited services.)

Important Notice to Persons on Medicare

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

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

- hospitalization
- physician services
- other approved items and services

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

Before You Buy This Insurance

✓ 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.)

Important Notice to Persons on Medicare

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

Important Notice to Persons on Medicare

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

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

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

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

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

Important Notice to Persons on Medicare

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice

• other approved items and services

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

Before You Buy This Insurance

✔ Check the coverage in **all** health insurance policies you already have.

✔ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✔ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

Important Notice to Persons on Medicare

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

Medicare generally pays for most or all of these expenses.

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

• hospitalization

• physician services

• hospice care

• other approved items & services

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

Before You Buy This Insurance

✔ Check the coverage in **all** health insurance policies you already have.

✔ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✔ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

Important Notice to Persons on Medicare

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

Medicare generally pays for most or all of these expenses.

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

• hospitalization

• physician services

• hospice

• other approved items and services

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

Before You Buy This Insurance

✔ Check the coverage in **all** health insurance policies you already have.

✔ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✔ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Pa.B. Doc. No. 99-42. Filed for public inspection January 8, 1999, 9:00 a.m.]

Title 64—SECURITIES

PART I. SECURITIES COMMISSION

[64 PA. CODE CHS. 202, 206, 302, 606, 609 AND 610]

Registration of Securities; Registration of Broker-Dealers, Agents and Investment Advisers; Administration

Statutory Authority

The Securities Commission (Commission), under the authority contained in sections 202(i), 206(b) and (d), 302(f), 606(d), 609(a) and (c) and 610 of the Pennsylvania Securities Act of 1972 (70 P. S. §§ 1-202(i), 1-206(b) and (d), 1-302(f), 1-606(d), 1-609(a) and (c) and 1-610) (act) amends regulations concerning the subject matter of the act to read as set forth at 28 Pa.B. 3950 (August 15, 1998).

Public Comments

One public comment was received with respect to amendments to § 302.063 (relating to financial institutions exempt from broker-dealer and agent registration) which was supportive of the amendments. No public comments were received with respect to any other amendments.

Comments of the Independent Regulatory Review Commission (IRRC)

By letter dated October 15, 1998, IRRC advised the Commission that it had no objections, comments or suggestions with respect to the amendments.

Summary and Purpose of the Amendments

§ 202.092. This amendment updates the accounting terminology used in this regulation.

§ 206.020. This amendment requires a certified public accountant to give a tax opinion in a public offering of interests in a direct participation program, such as oil and gas programs, equipment leasing programs and commodity pools, which are filed with the Commission under section 206 of the act.

§ 302.063. This amendment exempts financial institutions (banks, savings and loans and credit unions) and their representatives from registering as broker-dealers or agents under the act when securities transactions made by these entities and individuals on behalf of customers are performed through a contractual arrangement with a broker-dealer registered under the act even though the transactions may be effected on, or emanate from, the premises of a financial institution where retail deposits are taken.

§ 606.041. This amendment permits the Assistant Director of the Division of Licensing and Compliance to exercise certain Commission powers through delegated authority.

§ 609.032. This amendment updates the accounting terminology used in this regulation and makes it clear that the accounting definitions apply to all financial statements required to be filed under the act or regulations adopted thereunder.

§ 609.033. This amendment requires an accountant's report filed in the auditor's format to follow generally accepted auditing standards and reports filed in an accountant's review and compilation report format to follow the Statements on Standards for Accounting and Review Services of the American Institute of Certified Public Accountants. Public accountants may continue to prepare reports required to be filed for broker-dealers and investment advisers.

§ 609.034. This amendment permits issuers filing a registration statement under section 206 of the act, except issuers of interests in public direct participation programs, to submit 2 years of financial statements instead of 3. In the case of a small business issuer filing under section 206 for a public offering of corporate equity securities aggregating $1 million or less, the amendment allows use of reviewed financial statements in lieu of an audit. The amendment also requires that the financial statements appearing in a registration statement filed with the Commission under section 205 of the act comply with the relevant requirements of the United States Securities and Exchange Commission.

§ 609.036. The amendment updates accounting terminology used in the regulation.

§ 610.010. The amendment provides for the retention and destruction of records in conformity with schedules promulgated by the Commission which conform to Management Directives issued by the Office of Administration.

Persons Affected by these Amendments

With respect to amendments to § 202.092 (relating to guaranties of debt securities exempt), recipients of the proceeds of limited obligation revenue bonds issued by governmental instrumentalities who guaranty payments to the governmental instrumentality sufficient to pay the principal and interest on the bonds are affected by these amendments. The proposed changes, however, only update accounting terminology and do not affect the existing requirements of these amendments.

With respect to amendments to § 206.020 (relating to tax opinion in offerings of limited partnership interests), issuers of interests in public direct participation programs for which a registration statement is filed with the Commission under section 206 of the act are affected.

With respect to amendments to § 302.063, financial institutions, including banks, savings and loans and credit unions that effect transactions on behalf of customers under a contractual arrangement with a broker-dealer registered under the act are affected.

With respect to amendments to §§ 606.041 and 610.010 (relating to delegation and substitution; and destruction of documents and records), only the internal administrative affairs of the Commission are affected.

With respect to amendments to §§ 609.032, 609.033 and 609.036 (relating to definitions; accountants; and financial statements; annual reports), accountants preparing financial statements to be filed with the Commission are affected.

With respect to amendments to § 609.034 (relating to financial statements), issuers filing a registration statement with the Commission under section 205 or 206 of the act are affected.

Fiscal Impact

None of the amendments increase costs on the regulated community or the Commonwealth. The Commonwealth will not incur any revenue loss as a result of the amendments. The amendments will decrease regulatory costs to issuers filing a registration statement with the Commission under section 206 of the act.

Paperwork

None of the amendments impose new paperwork requirements. With respect to issuers filing a registration statement with the Commission under section 206 of the act, there will be a reduction in the amount of financial statements that must be filed.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on July 27, 1998, the Commission submitted a copy of the proposed rulemaking published at 28 Pa.B. 3950 to IRRC and the Chairpersons of the House Committee on Commerce and Economic Development and the Senate Committee on Banking and Insurance for comment and review. In compliance with section 5(b.1) of the Regulatory Review Act, the Commission also provided IRRC and the Committees with copies of all comments received as well as other documentation.

In preparing its final-form rulemaking, the Commission has considered all comments received from IRRC, the Committees and the public. This final-form rulemaking was deemed approved by the House Committee on Commerce and Economic Development and by the Senate Committee on Banking and Insurance on November 12, 1998. IRRC met on November 19, 1998, and approved the final-form rulemaking.

Availability in Alternative Formats

These amendments may be made available in alternative formats upon request. The Commission also will receive comments on this final-form rulemaking in alternative formats. TDD users should use the AT&T Relay Center (800) 854-5984. To make arrangements for alternative formats, contact Joseph Shepherd, ADA Coordinator, at (717) 787-6828.

Contact Person

The contact person is G. Philip Rutledge, Deputy Chief Counsel, Securities Commission, Eastgate Building, 1010 N. Seventh Street, 2nd Floor, Harrisburg, PA 17102-1410, (717) 783-5130.

Order

The Commission, acting under the authorizing statute, orders that:

(a) The regulations of the Commission, 64 Pa. Code Chapters 202, 206, 302, 606, 609 and 610, are amended by amending §§ 202.092, 206.020, 302.063, 606.041, 609.032—609.036 and 610.010 to read as set forth at 28 Pa.B. 3950.

(b) The Secretary of the Commission shall submit this order and 28 Pa.B. 3950 to the Office of Attorney General for approval as to form and legality as required by law.

(c) The Secretary of the Commission shall certify this order and 28 Pa.B. 3950 and deposit them with the Legislative Reference Bureau as required by law.

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

M. JOANNA CUMMINGS,
Secretary

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission relating to this document, see 28 Pa.B. 5920 (December 5, 1998).)

Fiscal Note: Fiscal Note 50-112 remains valid for the final adoption of the subject regulations.

[Pa.B. Doc. No. 99-43. Filed for public inspection January 8, 1999, 9:00 a.m.]