RULES AND REGULATIONS

Title 31—INSURANCE

INSURANCE DEPARTMENT

[31 PA. CODE CH. 89]

Medicare Supplement Insurance Minimum Standards

The Insurance Department (Department) amends Chapter 89, Subchapter K (relating to Medicare Supplement Insurance Minimum Standards) to read as set forth in Annex A. This final-form rulemaking is made under the authority of sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P.S. §§ 66, 186, 411 and 412), sections 5 and 9 of the Medicare Supplement Insurance Act (40 P.S. § 3105 and § 3109) and section 314 of the Accident and Health Filing Reform Act (40 P.S. § 3801.314).

Purpose

The purpose of this final-form rulemaking is to update the Commonwealth's requirements for Medicare supplement insurance (Medigap) plans in accordance with changes made to National Association of Insurance Commissioners (NAIC) Model Regulation No. 651. The NAIC model was revised in 2015 in accordance with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub.L. No. 114-10), which mandated certain changes to the benefit structure of the permissible standardized benefit plans for Medigap policies. In addition to updating the Commonwealth's Medigap regulations pertaining to Medigap plans, this final-form rulemaking also establishes an open enrollment period for certain individuals retroactively enrolled in Medicare Part B.

Comments and Responses

Notice of proposed rulemaking was published at 48 Pa.B. 517 (January 20, 2018), with a 30-day public comment period. Highmark, the Insurance Federation of Pennsylvania, Inc. (IFP), and Independence Blue Cross (IBC) submitted comments during the comment period. United Healthcare (UHC) submitted a comment on April 18, 2018. All comments were taken into consideration.

Highmark expressed no objections to the proposed amendments but sought clarification regarding whether § 89.777b(f)(7) allows individuals, who are eligible for Medicare Part B prior to January 1, 2020, to enroll in newly redesignated high deductible Plan G plans before January 1, 2020. Under § 89.777c(d), an individual who was eligible before January 1, 2020, may not be enrolled in a plan prior to that date, although these individuals may be made aware of the availability of the new plans.

IBC expressed two concerns in its February 20, 2018, comment. IBC withdrew the first half of its comment, which suggested an editorial change, on May 3, 2018, as it did not relate to the Annex published at 48 Pa.B. 517. With regard to the second portion of IBCs comment, the Department notes that it intends to revise the Outlines of Coverage samples on its web site after promulgation of this final-form rulemaking.

The IFP expressed support for the amendments, but raised concerns regarding § 89.781(g). Specifically, the IFP questioned the distinction between "ladle rating" and "attained age rating" and challenged the Department's statutory authority to promulgate this provision. The Department believes it has the statutory authority to promulgate the provision prohibiting these practices. However, because it is necessary for the Department to promulgate this regulation as soon as practicable, it is deleting § 89.781(g) from this final-form rulemaking. The Department intends to revisit adding this provision at a later date.

UHC's comments were also considered by the Department. First, UHC requested the Department clarify the definition of 2020 Standardized Medicare Supplement Plans to confirm that "issued or delivered" means "issued or delivered for effective dates on or after January 1, 2020." The Department notes that the term "issuance" is synonymous with the term "effective." However, the Department has removed the "or delivered" language in the definition to maintain consistency with the other definitions of plan types found in the existing regulations.

UHC also pointed out two typographical errors in § 89.777b. The use of the term "ready" instead of "newly" was mistakenly inserted by the Legislative Reference Bureau. The Department has corrected this error in this final-form rulemaking. The second typographical error appears to be a formatting construct in the printed version and need not be addressed by the Department. Next, UHC points out a typographical error in § 89.777c(a)(2) and suggests an editorial change to § 89.777c(b)(2)(iv). The Department deleted the redundant "and plan policy" language in § 89.777c(a)(2) and changed "Plan F" to "Plan G" in § 89.777c(b)(2)(iv) in this final-form rulemaking. Finally, UHC also points out an error in the *Federal Register*, which need not be addressed by the Department in this final-form rulemaking.

The Independent Regulatory Review Commission (IRRC) submitted two comments: (1) requesting that the Department address Highmark's question with regard to how the enrollment process is envisioned; and (2) requesting the Department meet with insurers to discuss § 89.781(g). Both comments have been addressed as previously explained.

Affected Parties

This final-form rulemaking applies to insurers licensed to transact accident and health business in this Commonwealth. Specifically, this final-form rulemaking applies to insurers offering Medigap policies.

Fiscal Impact

State government

There will not be a material increase in cost to the Department as a result of this final-form rulemaking.

General public

This final-form rulemaking will not impose costs and will not have a fiscal impact upon the general public.

Political subdivisions

This final-form rulemaking will not impose additional costs on political subdivisions.

Private sector

The insurance industry will likely not incur additional costs associated with complying with this final-form rulemaking.

Paperwork

This final-form rulemaking will not impose additional paperwork on the Department, as no filing is required to

be made by insurers. To the extent that insurers would need to update policy forms or enrollee literature, this final-form rulemaking may impose additional paperwork on insurers.

Effective Date

This final-form rulemaking will become effective upon final-form publication in the *Pennsylvania Bulletin*. Although this final-form rulemaking will be effective upon final-form publication, the benefit standards established by MACRA apply to all policies or certificates issued or delivered on or after January 1, 2020.

Sunset Date

The Department continues to monitor the effectiveness of regulations on a triennial basis. Therefore, a sunset date has not been assigned.

Contact Person

Questions or comments regarding this final-form rulemaking may be addressed in writing to Bridget Burke, Regulatory Coordinator, Insurance Department, 1341 Strawberry Square, Harrisburg, PA 17120, fax (717) 772-1969, briburke@pa.gov.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P.S. § 745.5(a)), on January 9, 2018, the Department submitted a copy of the notice of proposed rulemaking, published at 48 Pa.B. 517, to IRRC and the Chairpersons of the Senate Banking and Insurance Committee and the House Insurance Committee for review and comment.

Under section 5(c) of the Regulatory Review Act, IRRC and the House and Senate Committees were provided copies of comments received, as well as other documents when requested. In preparing this final-form rulemaking, the Department has considered all comments from IRRC and the public.

Under section 5.1(j.2) of the Regulatory Review Act (71 P.S. § 745.5a(j.2)), on July 18, 2018, this final-form rulemaking was deemed approved by the House and Senate Committees. Under section 5.1(e) of the Regulatory Review Act, IRRC met on July 19, 2018, and approved the final-form rulemaking.

Findings

The Commissioner finds that:

(1) Public notice proposed rulemaking was given under sections 201 and 202 of the act of July 31, 1968 (P.L. 769, No. 240) and the regulations thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(2) A public comment period was provided as required by law and all comments were considered.

(3) This final-form rulemaking does not enlarge the purpose of the proposed rulemaking published at 48 Pa.B. 517.

(2) This final-form rulemaking adopted by this order is necessary and appropriate for the administration and enforcement of the authorizing statutes.

Order

The Commissioner, acting under the authorizing statutes, orders that:

(a) The regulations of the Department, 31 Pa. Code Chapter 89, are amended by adding § 89.777c and amending §§ 89.772, 89.777b, 89.778 and 89.783 to read as set forth in Annex A, with ellipses referring to the existing text of the regulations.

(*Editor's Note*: Proposed § 89.781 was not adopted in this final-form rulemaking.)

(b) The Department shall submit this order and Annex A to IRRC and the House and Senate Committees as required by law.

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

(d) The Department shall certify this order and Annex A, as approved for legality and form, and deposit them with the Legislative Reference Bureau, as required by law.

(e) This final-form rulemaking shall take effect immediately upon publication of the *Pennsylvania Bulletin*.

JESSICA K. ALTMAN,
Insurance Commissioner

(*Editor's Note*: See 48 Pa.B. 4752 (August 4, 2018) for IRRC's approval order.)

Fiscal Note: Fiscal Note 11-256 remains valid for the final adoption of the subject regulations.

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:

1990 Standardized Medicare supplement benefit plan—

(i) A group or individual policy of Medicare supplement insurance issued on or after July 30, 1992, and prior to June 1, 2010.

(ii) The term includes Medicare supplement insurance policies and certificates renewed on or after July 30, 1992, which are not replaced by the issuer at the request of the insured.

2010 Standardized Medicare supplement benefit plan—A group or individual policy of Medicare supplement insurance issued on or after June 1, 2010.

2020 Standardized Medicare supplement benefit plan—A group or individual policy or certificate of Medicare supplement insurance issued on or after January 1, 2020.

Applicant—

* * * * *

§ 89.777b. Standard Medicare supplement benefit plans for 2010 Standardized Medicare supplement benefit plan policies or certificates issued or delivered on or after June 1, 2010.

(a) *Applicability*. The following standards apply to 2010 Standardized Medicare supplement benefit plan policies or certificates. 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 plan standards. Benefit plan standards applicable to Medicare

supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of § 89.777 (relating to Standard Medicare supplement benefit plans for 1990 Standardized Medicare supplement benefit plan policies or certificates issued or delivered on or after July 30, 1992 and prior to June 1, 2010).

(b) *Basic (core) and additional benefits.*

(1) 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 § 89.776a(2) (relating to benefit standards for policies or certificates issued or delivered on or after June 1, 2010). An issuer shall also offer a policy or certificate to prospective insureds meeting the Plan B benefit plan.

(2) If an issuer makes available any of the additional benefits described in § 89.776a(3), or offers standardized benefit Plans K or L (as described in subsections (f)(8) and (9)), the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in paragraph (1) a policy form or certificate form containing either standardized benefit Plan C as described in subsection (f)(3) or standardized benefit Plan F (as described in subsection (f)(5)).

(c) No 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 subsection (g) and § 89.777a (relating to Medicare select policies and certificates).

(d) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans 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 § 89.776a(2) and (3) and list the benefits in the order shown in this section. For purposes of this subsection, "structure, language, and format" means style, arrangement and overall content of a benefit.

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

(f) The make up of 2010 Standardized Medicare supplement benefit plans shall be as follows:

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

(2) Standardized Medicare supplement benefit Plan B shall include only the following: the basic (core) benefit as defined in § 89.776a(2), plus 100% of the Medicare Part A deductible as defined in § 89.776a(3)(i).

(3) Standardized Medicare supplement benefit Plan C shall include only the following: the basic (core) benefit as defined in § 89.776a(2), plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in § 89.776a(3)(i), (iii), (iv) and (vi).

(4) Standardized Medicare supplement benefit Plan D shall include only the following: the basic (core) benefit as defined in § 89.776a(2), plus 100% of the Medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in an foreign county as defined in § 89.776a(3)(i), (iii) and (vi).

(5) Standardized Medicare supplement Plan F shall include only the following: the basic (core) benefit as defined in § 89.776a(2), plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of 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 § 89.776a(3)(i), (iii) and (iv)—(vi).

(6) Standardized Medicare supplement 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 basic (core) benefit as defined in § 89.776a(2), plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign county as defined in § 89.776a(3)(i), (iii) and (iv)—(vi). 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 basis of the deductible shall be $1,500 and shall be adjusted annually from 1999 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.

(7) Standardized Medicare supplement benefit Plan G shall include only the following: the basic (core) benefit as defined in § 89.776a(2), plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign county as defined in § 89.776a(3)(i), (iii), (v) and (vi). Effective January 1, 2020, a standardized benefit plan redesignated as high deductible Plan G under § 89.777c(b)(2)(iv) (relating to Standard Medicare supplement benefit plans for 2020 Standardized Medicare supplement benefit plans issued or delivered to individuals newly eligible for Medicare on or after January 1, 2020) may be offered to an individual who was eligible for Medicare prior to January 1, 2020.

(8) Standardized Medicare supplement Plan K shall include only the following:

(i) *Part A hospital coinsurance, day 61 through day 90.* Coverage of 100% of the Part A hospital coinsurance amount for each day used from day 61 through day 90 in any Medicare benefit period.

(ii) *Part A hospital coinsurance, day 91 through day 150.* Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from day 91 through day 150 in any Medicare benefit period.

(iii) *Part A hospitalization after lifetime reserve days are exhausted.* On exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

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§ 89.777c. Standard Medicare supplement benefit plans for 2020 Standardized Medicare supplement benefit plans issued or delivered to individuals newly eligible for Medicare on or after January 1, 2020.

(a) *Applicability.*

(1) Except as provided in subsection (d), this section applies to a 2020 Standardized Medicare supplement plan issued or delivered to an individual newly eligible for Medicare on or after January 1, 2020, by reason of:

(i) Attainment of 65 years of age on or after January 1, 2020.

(ii) Entitlement to Medicare Part A benefits under section 226(b) or 226A of the Social Security Act (42 U.S.C.A. §§ 426(b) and 426-1) on or after January 1, 2020.

(iii) Entitlement to benefits under section 226(a) of the Social Security Act on or after January 1, 2020.

(2) Benefit plan standards applicable to a Medicare supplement policy or certificate issued or delivered to individuals eligible for Medicare before January 1, 2020, remain subject to § 89.777b (relating to Standard Medicare supplement benefit plans for 2010 Standardized Medicare supplement benefit plan policies or certificates issued or delivered on or after June 1, 2010).

(b) *Benefit requirements.* A 2020 Standardized Medicare supplement benefit plan that is advertised, solicited, delivered or issued for delivery in this Commonwealth to an individual newly eligible for Medicare as set forth in subsection (a)(1):

(1) May not provide coverage of the Medicare Part B deductible.

(2) Must meet the standards and requirements of § 89.777b except that:

(i) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and must provide the benefits in § 89.777b(f)(3) but may not provide coverage for any portion of the Medicare Part B deductible.

(ii) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and must provide the benefits in § 89.777b(f)(5) but may not provide coverage for any portion of the Medicare Part B deductible.

(iii) Standardized Medicare supplement benefit Plans C, F and high deductible Plan F may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

(iv) Standardized Medicare supplement benefit high deductible Plan F is redesignated as high deductible Plan G and must provide the benefits in § 89.777b(f)(6) but may not provide coverage for any portion of the Medicare Part B deductible. The Medicare Part B deductible paid by a beneficiary enrolled in a Standardized Medicare supplement benefit high deductible Plan G plan shall be considered an out-of-pocket expense for purposes of meeting the annual high deductible.

(v) For purposes of this section, the references to Plans C and F in § 89.777b(b)(2) are deemed to be references to Plans D and G, respectively.

(c) *Guaranteed issue for eligible persons.* For purposes of § 89.790(e) (relating to guaranteed issued for eligible persons), in the case of an individual newly eligible for Medicare on or after January 1, 2020, any reference to a standardized Medicare supplement benefit policy classified as Plan C, F or high deductible Plan F is deemed to be a reference to a standardized Medicare supplement benefit Plan D, G or high deductible Plan G, respectively, that meets the requirements of this subsection and subsection (d).

(d) *Offer of redesignated plans to individuals other than those newly eligible.* On or after January 1, 2020, a standardized Medicare supplement benefit plan described in subsection (b)(2)(iv) may be offered to an individual who was eligible for Medicare prior to January 1, 2020, under § 89.777b(f)(7).

§ 89.778. Open enrollment.

(a) *Prohibitions regarding denial, issuance and pricing of Medicare supplement policies or certificates.*

(1) 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 either of the following occurs:

(i) An individual enrolled for benefits under Medicare Part B.

(ii) An applicant who is retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration received notice of retroactive eligibility to enroll.

(2) 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) *Exclusion of benefits based on a pre-existing condition prohibited.* 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) *Reduction of the period of a pre-existing condition exclusion.* 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) *Prevention of the exclusion of benefits under a policy.* Except as provided in subsections (b) and (c) and §§ 89.789 and 89.790 (relating to prohibition against preexisting conditions, waiting periods, elimination periods and probationary periods in replacement policies or certificates; and guaranteed issue for eligible persons), 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.

§ 89.783. Required disclosure provisions.

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

(1) Issuers shall provide an outline of coverage to applicants at the time the application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant.

(2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12 point type, immediately above the company name:

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

(3) The outline of coverage provided to applicants under this section consists of four parts: a cover page, premium information, disclosure pages and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format required in this paragraph in no less than 12 point type. All plans shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(4) Once the Department has approved the format, an "Outline of Coverage" may be modified to reflect Medicare changes to rates, deductible and co-payment requirements 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 must be included in the outline of coverage in the order required in this paragraph:

PREMIUM INFORMATION
(Boldface Type)

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

READ YOUR POLICY VERY CAREFULLY
(Boldface Type)

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

RIGHT TO RETURN POLICY
(Boldface Type)

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

POLICY REPLACEMENT
(Boldface Type)

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

NOTICE
(Boldface Type)

This policy may not fully cover all of your medical costs. (for producers:) Neither (insert company's name) nor its producers are connected with Medicare.

(for direct response:) (insert company's name) is not connected with Medicare.

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

COMPLETE ANSWERS ARE VERY IMPORTANT
(Boldface Type)

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

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

(Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts as provided in paragraph (6). No more than four plans may be shown on one chart. An issuer may use additional benefit plan designations on these charts pursuant to § 89.777b(e)).

(Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Commissioner.)

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

(e) *Notice regarding policies or certificates which are not Medicare supplement policies.*

(1) An accident and sickness insurance policy or certificate, other than a Medicare supplement policy; a policy issued under a contract under section 1876 of the Social Security Act (42 U.S.C.A. § 1395mm), disability income policy; or other policy identified in § 89.771(b) (relating to applicability and scope) issued for delivery in this Commonwealth to persons eligible for Medicare, shall notify the insured under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall be printed or attached to the first page of the

outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds.

The notice shall be at least 12 point type and shall contain the following language:

"THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CONTRACT). If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subsection (e)(1) shall disclose the extent to which the policy duplicates Medicare. The disclosure statement shall be provided in the form required by the Department as set forth in the Medicare Supplement forms relating to Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare as a part of, or together with, the application for the policy or certificate.

(f) *Availability of forms.* Applicable forms relating to Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare, Refund Calculations and Reporting of Duplicate Medicare Policies for Medicare Supplement Chapter 89 are available upon request from the Department in printed and electronic formats. In addition, notice will be published, in the *Pennsylvania Bulletin*, of the availability of amended Medicare Supplement forms when revisions are made. These Medicare Supplement forms will be made available on the Department's web site at www.insurance.pa.gov.

[Pa.B. Doc. No. 18-1400. Filed for public inspection September 7, 2018, 9:00 a.m.]