CHAPTER 89. APPROVAL OF LIFE, ACCIDENT AND HEALTH INSURANCE

Authority

The provisions of this Chapter 89 issued under section 354 of The Insurance Company Law of 1921 (40 P. S. § 477b), unless otherwise noted.

Source

The provisions of this Chapter 89 adopted July 1, 1969, unless otherwise noted.

Cross References

This chapter cited in 31 Pa. Code § 89b.2 (relating to purpose).

Subchapter A. REQUIREMENTS FOR ALL POLICIES AND FORMS

GENERAL PROVISIONS

PREPARATION OF FORMS

Cross References

This subchapter cited in 31 Pa. Code § 89.102 (relating to guidelines for approval of forms).

GENERAL PROVISIONS

§ 89.1. Definitions.

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

Act—The Insurance Company Law of 1921 (40 P. S. §§ 341—991).

Advertisement—As defined in § 51.1 (relating to definitions).

Department—The Insurance Department of the Commonwealth.

Authority

The provisions of this § 89.1 amended under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); sections 510—514 of The Insurance Company Law (40 P. S. §§ 510—514); and section 3(a) of the Accident and Health Filing Reform Act (40 P. S. § 3803(a)).

Source

The provisions of this § 89.1 amended November 22, 2002, effective November 23, 2002, 32 Pa.B. 5747. Immediately preceding text appears at serial page (287350).

§ 89.2. Scope.

This chapter contains the guidelines used by the Department in reviewing the policies, rates and related forms for individual and group life, accident and health insurance.

§ 89.3. [Reserved].

Source

The provisions of this § 89.3 reserved November 22, 2002, effective November 23, 2002, 32 Pa.B. 5747. Immediately preceding text appears at serial pages (287350) and (214541).

§ 89.4. [Reserved].

Source

The provisions of this § 89.4 reserved November 22, 2002, effective November 23, 2002, 32 Pa.B. 5747. Immediately preceding text appears at serial page (214541).

§ 89.5. [Reserved].

Source

The provisions of this § 89.5 reserved November 22, 2002, effective November 23, 2002, 32 Pa.B. 5747. Immediately preceding text appears at serial pages (214541) to (214542).

PREPARATION OF FORMS

§ 89.11. [Reserved].

Source

The provisions of this § 89.11 reserved November 22, 2002, effective November 23, 2002, 32 Pa.B. 5747. Immediately preceding text appears at serial pages (214542) and (287707).

Cross References

This section cited in 31 Pa. Code § 90c.12 (relating to form number); 31 Pa. Code § 90d.2 (relating to general provisions); 31 Pa. Code § 90d.9 (relating to riders); 31 Pa. Code § 90e.2 (relating to general provisions); 31 Pa. Code § 90e.11 (relating to riders); 31 Pa. Code § 90f.2 (relating to general provisions); 31 Pa. Code § 90f.13 (relating to riders); 31 Pa. Code § 90g.2 (relating to general provisions); 31 Pa. Code § 90g.13 (relating to riders); 31 Pa. Code § 90h.2 (relating to general provisions); and 31 Pa. Code § 90h.11 (relating to riders).

§ 89.12. Application forms.

(a) When submitting a policy form to which a copy of the application will be attached when the policy is issued, a copy of the application shall be attached to the policy form. If the form of the application has already been approved, the form number and date of approval shall be shown either on the form or in the transmittal letter.

(b) If it is the practice of the insurer to attach a reduced size reproduction of the application to a form when issued, the application should be attached to each copy of the form submitted. The application should be legibly reproduced in the size to be used in the contract.

(c) An application which includes a provision for home office endorsements or corrections may not be approved for use unless it is specifically stipulated therein that a change may not be made in the amount of insurance, the age at issue, the plan of insurance or benefits applied for by the endorsements or corrections. This subsection does not apply to group applications.

(d) Applications shall contain clear and direct questions by the insurer permitting answers by the applicant only in the form of direct statements of known facts. Applications may not contain questions or representations based on indefinite or ambiguous terms or which are inconsistent with policy provisions and may not require the making of warranties by the applicant.

(e) An insurer may include questions as to demographic factors, including race and ethnicity, on an application subject to all of the following:

(1) The application clearly states that the disclosure of the data is voluntary.

(2) Questions as to the data include the following answer options verbatim:

(i) Prefer Not to Answer.

(ii) Other.

(3) At the time of application or when the data is collected, the insurer provides to the insured a written statement that contains the following information:

(i) The data will be maintained as private.

(ii) The data may not be used by the insurer for eligibility determinations, underwriting or rating purposes.

(iii) The insurer may not deny an application based on the applicant's refusal to answer the questions related to demographic data on the application.

(4) At the time of application or when the data is collected, the insurer provides a written explanation to the insured regarding all of the following:

(i) Why the data is being requested by the insurer.

(ii) How the data will support efforts to provide equitable coverage.

(5) The insurer provides a written attestation to the Department that the insurer's application, collection and use of data meets Federal and State law regarding unfair discrimination, including all of the following:

(i) The insured's data is maintained as private.

(ii) The insured's data may not be used by the insurer for eligibility determinations, underwriting or rating purposes.

(iii) The insurer may not deny an application based on the applicant's refusal to answer the questions related to demographic data on the application.

(6) The insurer shall provide the written attestation in paragraph (5) for each product by the following dates:

(i) June 20, 2024, for products in existence as of the effective date of this regulation.

(ii) The date the product is filed.

(iii) The date that there is a material change to the application or data collection process, even if not required to be filed.

(f) Nothing in this section may be construed to require an insurer to collect demographic information, including race and ethnicity data, at the time of application or otherwise.

Authority

The provisions of this § 89.12 amended under sections 206, 506, 1501, and 1502 of The Administrative Code of 1929 (71 P.S. §§ 66, 186, 411 and 412); section 314 of the Accident and Health Filing Reform Act (40 P.S. § 3801.314); and the Unfair Insurance Practices Act (40 P.S. §§ 1171.1—1171.15).

Source

The provisions of this § 89.12 amended December 22, 2023, effective December 23, 2023, 53 Pa.B. 7932. Immediately preceding text appears at serial pages (409715) to (409716).

Cross References

This section cited in 31 Pa. Code § 89.12a (relating to application exceptions—statement of policy); 31 Pa. Code § 90c.5 (relating to underwriting questions); 31 Pa. Code § 90c.6 (relating to home office endorsements/corrections provision); and 31 Pa. Code § 90c.8 (relating to prohibited terminology).

§ 89.12a. Application exceptions—statement of policy.

Notwithstanding § 89.12(e) (relating to application forms), to foster diversity, equity and inclusion efforts, an insurer may, on an application, collect race and ethnicity data for diversity, equity and inclusion purposes only.

Source

The provisions of this § 89.12a added April 8, 2022, effective April 9, 2022, 52 Pa.B. 2128.

§ 89.13. Use of certain words and terms.

(a) The use of policy captions or descriptions such as ''all coverage'' or ''complete coverage'' is prohibited. The purpose of this section is to prevent misunderstanding in the minds of the insured public.

(b) A policy form bearing a caption or reference that this is a ''Pennsylvania'' policy or a ''Standard'' policy will not be considered for approval, except if the forms are so designated by statute or Departmental regulation. The purpose of this section is to prevent misunderstanding in the minds of the insured public. Use of words or abbreviations thereof as a part of the distinguishing form number are acceptable, however, if deemed necessary or convenient to the identification of the form.

(c) The word ''special'' may not be used which might reasonably cause the insured to believe that he is receiving preferential treatment.

(d) The word ''compensation'' may not be used which might reasonably cause the policyholder to be confused with workmen's compensation coverage.

Cross References

This section cited in 31 Pa. Code § 90c.8 (relating to prohibited terminology); 31 Pa. Code § 90d.6 (relating to prohibited terminology); 31 Pa. Code § 90e.8 (relating to prohibited terminology); 31 Pa. Code § 90f.9 (relating to prohibited terminology); 31 Pa. Code § 90g.9 (relating to prohibited terminology); and 31 Pa. Code § 90h.7 (relating to prohibited terminology).

§ 89.14. Dismemberment, death or surgical benefits.

In contracts providing specified benefits for dismemberment, death or surgical operations, if the insurer limits its liability to one such loss as a result of a single accident, the contract shall provide that the insured is entitled to receive the largest amount applicable.

Authority

The provisions of this § 89.14 amended under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412).

Source

The provisions of this § 89.14 adopted April 12, 2002, effective April 13, 2002, 32 Pa.B. 1847.

§ 89.15. Simultaneous sale of insurance and equity products.

A program which contemplates the simultaneous sale of insurance and equity products shall be submitted to the Department for review in accordance with the following guidelines:

(1) The prospective purchaser shall be given the option to purchase either the insurance product or the equity product completely independent of one another, and shall be clearly advised to this effect by the agent and in all sales material.

(2) The premium charged for the insurance product shall be a separate identifiable charge and be shown as such on sales material, bill, statement or draft used in connection with the program.

(3) Sales material or sales presentation shall separately set forth the matters pertaining to the insurance product.

(4) The premium rate for the insurance product may not be dependent upon the purchase of an equity product, fluctuate or vary with the investment experience of an equity product or vary with the amount of equity product purchased or contracted to be purchased.

(5) At any time subsequent to a simultaneous sale, the purchaser shall be given the right to divest himself of either the insurance or the equity product.

(6) A policy, contract or related form may not contain a provision which would automatically make payable insurance benefits to facilitate payment of an equity product, provided that with the consent of the insurer the beneficiary of the benefit may, by written instruction subsequent to the time he becomes eligible for the benefit, direct that all or part of the benefit be applied toward the purchase of an equity product.

(7) The term equity product as used herein may not include a variable annuity.

Source

The provisions of this § 89.15 adopted September 22, 1970, effective September 23, 1970, 1 Pa.B. 336.

§ 89.16. Riders and endorsements.

(a) Endorsements, if printed on the form or to be applied by stamp, shall be separately submitted in duplicate on the letterhead of the insurer for approval or filing.

(b) ''Open face'' or ''blank'' amendment forms, riders or endorsements may be used to change variable or illustrative material without submission to the Department.

(c) A rider or endorsement which reduces or eliminates coverage under the policy shall provide for signed acceptance by the policy owner, except in the case of a rider or endorsement which is used only at the time of policy issue.

(d) With respect to impairment riders, a representative selection of the type of fill-in material shall be shown when submitting the form. Additional or alternative material which differs in fundamental approach should also be submitted at the time when the material is to be used. The material may not be used with forms delivered in this Commonwealth after receipt of nonacceptance by the Department.

Cross References

This section cited in 31 Pa. Code § 90e.6 (relating to amendment of contract).

§ 89.17. [Reserved].

Source

The provisions of this § 89.17 reserved November 22, 2002, effective November 23, 2002, 32 Pa.B. 5747. Immediately preceding text appears at serial page (214546).

§ 89.18. Miscellaneous requirements.

(a) *Riot injuries.* If a policy contains an exception for injuries arising out of riots, the exception should be confined to those instances in which the insured is injured while participating in the riot.

(b) *Rate books.* Rate books and revisions thereof should be submitted for filing. The name of the insurer should appear on revision pages, supplements and the like, in order to facilitate proper filing in the Department. This subsection does not apply to group insurance.

Authority

The provisions of this § 89.18 amended under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); sections 510—514 of The Insurance Company Law (40 P. S. §§ 510—514); and section 3(a) of the Accident and Health Filing Reform Act (40 P. S. § 3803(a)).

Source

The provisions of this § 89.18 amended November 22, 2002, effective November 23, 2002, 32 Pa.B. 5747. Immediately preceding text appears at serial page (214546).

§§ 89.21—89.23. [Reserved].

Source

The provisions of these § 89.21—89.23 reserved November 22, 2002, effective November 23, 2002, 32 Pa.B. 5747. Immediately preceding text appears at serial pages (214546) to (214547).

Subchapter B. REQUIREMENTS FOR LIFE INSURANCE

INDIVIDUAL POLICIES

Sec.
89.31—89.37. [Reserved].
89.41. General filing requirements.
89.42. Nonforfeiture value requirements.
89.43. Accidental death benefit.

PREMIUM FINANCING FOR COLLEGE STUDENTS

89.51. Promissory notes.
89.52. Policy provision.
89.53. Policy receipt or acceptance form.
89.54. Sales materials.

GROUP POLICIES

89.61. General filing requirements.
89.62. Group annuity policies and forms.

Cross References

This subchapter cited in 31 Pa. Code § 89.102 (relating to guidelines for approval of forms).

INDIVIDUAL POLICIES

§§ 89.31—89.37. [Reserved].

Source

The provisions of these §§ 89.31—89.37 reserved December 28, 1973, effective January 1, 1974, 3 Pa.B. 2963. Immediately preceeding text appears at serial pages (214542) and (287707).

§ 89.41. General filing requirements.

(a) *Incontestable clauses.* Under sections 410 and 420C of the act (40 P. S. §§ 510 and 574) the permissible exclusions to the incontestable clause are clearly set forth and others are not permitted. Consequently, the hazard of engaging in

military or naval services, except in time of war, and the hazard of aviation may not be made exclusions to the incontestable clause.

(b) [Reserved].

(c) *Dividends payable to third parties.* If dividends are to be paid to a third party, a statement shall be included showing the right of revocation of the policyholder.

(d) *Special premium rates.* In the case of rated policies calling for higher premiums than the corresponding standard contracts, the words ''Special Premium Class,'' or a similar designation, shall be included in the brief description or on the specifications page.

(e) *Work sheets.* Because of the multitude of policies with almost infinite variation in nomenclature and language being submitted to the Department, it is requested that companies submitting new forms for approval also submit the work sheets showing the formulae for the net renewal premiums and for the reserves expressed in standard actuarial symbols with all pertinent data as to valuation basis, surrender charges, paid-up options and the like listed. The form shall show the name of the company and its address and identify the individual or firm responsible for the ''certification'' that the methodology is consistent with the premiums and benefits provided by the policy.

Source

The provisions of this § 89.41 amended July 22, 1977, effective July 23, 1977, 7 Pa.B. 2059. Immediately preceding text appears at serial page (13322).

§ 89.42. Nonforfeiture value requirements.

(a) *General.* The nonforfeiture values (for the age for which the form is filled in for a typical plan of insurance) to be issued under a particular policy form should be included. The Department has approved reference to the Commissioners' Standard Non-Forfeiture Value Method in lieu of explanation of the method of calculating cash values under the Standard Non-Forfeiture Law, section 410A of the act (40 P.S. § 510.1), and insurers using the method may refer thereto in the forms submitted. If no nonforfeiture values develop, the submission letter should so state.

(b) *Recommended statement in policy.* It is suggested that a provision be included in the policy substantially similar to the following:

> The cash values and nonforfeiture benefits available under this policy are equal to or greater than the minimum required by statute of the state in which this policy is delivered.

[Next page is 89-11.]

(c) *Automatic premium loan.* An automatic premium loan provision should be separately captioned and not included under or with the nonforfeiture provisions.

(d) *Substandard plans.* Substandard plans in which the extended insurance option is not available shall indicate by the proper text in the policy and endorsements that such option and values are not applicable. Tables which contain headings and spaces for the insertion of extended insurance values shall be printed, overprinted or stamped in a prominent manner to indicate that, in cases in which the values are not granted, the values are not applicable.

(e) *Nonforfeiture benefit limitations.* Nonforfeiture benefit limitations shall conform with the following:

(1) Insurers may offer extended term insurance or paid-up insurance as a nonforfeiture benefit. These benefits need not include supplementary built-in insurance benefits provided for while the policy is in force, nor need they include benefits provided by riders attached thereto.

(2) Where the nonforfeiture benefits of a policy do not apply to supplementary benefits which are built into the policy or attached by riders, the policyholder shall be so notified. Notification shall be in the following or comparable form:

> Any insurance continued under these nonforfeiture provisions shall not include benefits which supplement the basic life insurance benefit, whether these supplemental benefits are mentioned in the policy itself or provided by a rider attached to the policy, unless specifically provided otherwise where the supplemental benefit is described.

(3) The provision set forth in paragraph (2) should be included in the first section of the policy which describes nonforfeiture values.

(i) If the provision is located elsewhere in the policy, it shall be in a place where it is equally or more visible.

(ii) Where supplemental benefits are described in a rider to the policy and not in the policy itself, notification of nonapplicability of the benefits as a nonforfeiture value may be made in the rider describing the benefit. The notice shall be prominently located.

(iii) Policy and rider forms will be disapproved which do not include the provision in a location acceptable to the Department.

(4) The provision set forth in paragraph (2) shall be required in life insurance policies or riders issued 90 days after the effective date of this subsection. Compliance may be made by endorsement to policies or riders issued 90 days after the effective date but before January 1, 1976. After January 1, 1976, life insurance forms shall incorporate the provision into the policy or rider itself.

Source

The provisions of this § 89.42 amended October 11, 1974, effective October 12, 1974, 4 Pa.B. 2173. Immediately preceding text appears at serial page (7752).

Cross References

This section cited in 31 Pa. Code § 90d.5 (relating to termination of coverage); 31 Pa. Code § 90f.8 (relating to termination of coverage); 31 Pa. Code § 90g.8 (relating to termination of coverage); and 31 Pa. Code § 90h.6 (relating to termination of coverage).

§ 89.43. Accidental death benefit.

A provision for accidental death benefit may not contain a requirement that death must occur within a specific time period.

Source

The provisions of this § 89.43 adopted June 23, 1978, effective June 24, 1978, 8 Pa.B. 1678.

Cross References

This section cited in 31 Pa. Code § 90d.4 (relating to exclusions and restrictions).

PREMIUM FINANCING FOR COLLEGE STUDENTS

§ 89.51. Promissory notes.

(a) If a promissory note is to be executed by the insured in connection with the financing of the insurance premium, this fact shall be set forth in the application immediately preceding the signature of the applicant, showing the amount of the note, the true rate of interest and the amount of down payment made at the time of taking the application.

(b) If the insured is a minor and executes a promissory note in connection with his premium payment or payments, the note shall be co-signed by the parent, legal guardian or adult spouse of the insured.

(c) If a promissory note is executed in connection with the financing of less than the full first year's premium, the balance of the premium shall be paid by the applicant at the time the application is taken.

(d) A down payment shall be paid by the applicant and the payment directly or indirectly made by the agent under any circumstances shall be deemed a rebate or inducement.

Source

The provisions of this § 89.51 adopted January 20, 1970.

§ 89.52. Policy provision.

(a) A premium financing arrangement shall be fully set forth and described in the policy, and a copy of a promissory note executed by the insured and an assignment thereof shall be attached to the policy.

(b) A copy of an assignment of a promissory note executed by the insured subsequent to the issuance of the policy and copies of additional promissory notes executed by the insured subsequent to the issuance of the policy shall be delivered to the insured for attachment to the policy.

(c) The maximum amount of premium financing arrangement which may be entered into in connection with the purchase of the policy shall also be set forth in the policy, and shall be in accordance with reasonable and sound underwriting practices as determined by the company.

Source

The provisions of this § 89.52 adopted January 20, 1970.

§ 89.53. Policy receipt or acceptance form.

(a) Upon delivery of the policy, a policy receipt or acceptance form shall be executed by the insured acknowledging that:

(1) The policy has been issued as presented.

(2) The insured understands the provisions and obligations of the premium financing arrangement and the indebtedness which he has incurred.

(b) A policy receipt or acceptance form should be registered by number in the home office of the company.

(c) The receipts or acceptance forms shall accompany the policy at the time of delivery only, and may not be made available at any other time or for another purpose.

(d) Until the executed policy receipt or acceptance form has been received and filed in the home office of the company, no promissory note executed by the insured should be sold or otherwise transferred or assigned, and no commission on the sale should be paid to an agent.

Source

The provisions of this § 89.53 adopted January 20, 1970.

§ 89.54. Sales materials.

(a) Sales materials, including promissory note forms and other forms used in the sale of the insurance programs, shall be submitted to this Department with a letter of transmittal at the time of submitting the policy form in question for approval.

(b) Additions or amendments to the materials may not be made by the company unless first submitted and found acceptable to this Department.

GROUP POLICIES

§ 89.61. General filing requirements.

(a) *Conformity to definition.* A group life policy issued for delivery in this Commonwealth will not be approved by the Department which does not apply to a group filing within the definition of a group qualified for the insurance under the Pennsylvania Group Life Statute (40 P. S. §§ 532.1—532.9). If any element

of doubt exists as to whether a particular group is one authorized by the statute, the question shall be referred to the Department for review in advance of filing.

(b) *Identification of insured.* Group life and annuity certificates filed with the Department shall provide for the identification of the insured. This may be accomplished by having the name of the insured stated on the certificate or any code which could be used in the identification of the certificate holder.

(c) *Beneficiary.* Concerning group life certificates, each employe insured under a form of group life insurance shall be given written evidence of his beneficiary designation, if any.

(d) *Variations in policies.* Group life policies, their certificates and the intended insert pages reflecting possible variations shall be accepted for approval, provided that the filing is accompanied by a statement showing the combinations of pages which will be used for the different types of policies.

(e) *Dependent policies.* Dependent group life is not permissible.

(f) *Certificates.* Certificates shall conform with all of the following:

(1) Certificates shall be issued to the policy owner within a reasonable period of time after issuance of the master policy for delivery to each person insured.

(2) Certifying language shall be used in certificates.

(3) Certificates should state the benefits applicable to the person insured or state the schedule of benefits applicable to the class to which he belongs.

(g) *Modes of settlement.* A statement concerning the availability of optional modes of settlement should appear in the certificate as well as in the master policy.

(h) *Accidental death benefit.* A provision for accidental death benefit may not contain a requirement that death must occur within a specific time period.

Source

The provisions of this § 89.61 amended June 23, 1978, effective June 24, 1978, 8 Pa.B. 1678. Immediately preceding text appears at serial page (14249).

§ 89.62. Group annuity policies and forms.

(a) Variable annuities shall conform with Chapter 85 (relating to variable annuity and variable accumulation annuity contracts).

(b) A group annuity master policy should state the type of an annuity funding plan used, such as regular deferred, deposit administration, separate account and the like.

(c) A statement concerning the availability of optional modes of settlement shall appear in the certificates as well as in the master policy.

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Subchapter C. REQUIREMENTS FOR ACCIDENT AND HEALTH INSURANCE

INDIVIDUAL POLICIES

Sec.

GROUP POLICIES

Source

The provisions of this Subchapter C amended August 1, 1975, effective August 2, 1975, 5 Pa.B. 1972, unless otherwise noted.

Cross References

This subchapter cited in 31 Pa. Code § 89.102 (relating to guidelines for approval of forms).

INDIVIDUAL POLICIES

§ 89.71. General.

Submissions shall comply with sections 616—621 of the act (40 P. S. §§ 751—756). The NAIC Official Guide for the Filing and Approval of A & H

Contracts (3rd Edition) shall serve as a general guide for review in the Department, except to the extent that the guide is inconsistent with the laws of the Commonwealth.

§ 89.72. Applications.

(a) Opinion-type questions regarding the past or present health of the applicant should provide that the applicant is to answer to the best of his knowledge and belief.

(b) A provision may not be permitted in an application which changes the terms of the policy to which it is attached.

§ 89.73. Required statements in policies.

(a) There shall be imprinted on the face of the policy the ''Notice of Insured's Right to Examine Policy for Ten Days,'' as required by section 617 of the act (40 P. S. § 752). The provision shall be worded that the insured is given the option for a full refund. On booklet-type policies this provision shall appear on the outside cover portion of the policy.

(b) The words ''This Is An Assessable Policy'' shall be printed prominently on the policy face and filing back, if any, of each assessable policy in at least 16-point type.

§ 89.74. Renewability and cancellation of policies.

(a) Provisions concerning renewability or cancellation by the insurer shall appear on the first page or reference shall be made thereto in a brief description on the face page and on the filing back, if any.

(b) Policies which are noncancellable and guaranteed renewable shall state clearly the period of time during which they are to be guaranteed renewable and shall provide that the company cannot cancel the policy and that the company cannot increase the premium.

(c) Nonrenewal of individual accident and health policies may not be based upon deterioration of physical or mental health.

(d) Policy nonrenewal should also be limited to the anniversary date.

§ 89.75. Use of certain words and terms.

(a) A policy containing, as part of its title, words such as ''special'' or ''preferred'' which are used in a misleading fashion, or words such as ''Union,'' ''Labor,'' ''Miner,'' and the like in its title which could associate it with a particular organization, association or business will not be approved.

(b) Policies which are to be issued to supplement or implement Medicare may not have policy titles or headings which could confuse them with the Federal Medicare Program.

§ 89.76. Suspension and termination.

(a) A policy may not contain a provision for its automatic termination upon the happening of any loss, except a loss which has exhausted all possible benefits under the policy.

(b) A policy which provides for a suspension of coverage while the insured is in military service the policy shall provide that upon written request the insurer will refund unearned premiums for the period of the suspension.

§ 89.77. Exclusions.

(a) The following is a list of the maximum applicable exclusions which shall be permitted in addition to those specified under section 618 of the act (40 P. S. § 753). The wording of the exclusions is illustrative and is intended to indicate the general intent of the Department. Alternate wording is permissible as long as the meaning preserves the general intent of the exclusions:

(1) *General exclusions.* General exclusions shall conform with the following:

(i) Loss sustained or expenses incurred while a member of the armed forces of any nation, or losses sustained or expenses incurred as a result of enemy action or act of war whether declared or undeclared.

(ii) Normal pregnancy, childbirth, miscarriage and abortion.

(iii) Suicide or intentionally self-inflicted injuries.

(iv) Sickness or injury covered by a workmen's compensation act or occupational disease law or by United States Longshoreman's and Harbor Worker's Compensation Act.

(v) Mental or nervous or emotional disorders.

(vi) Exclusions which, in the opinion of the Commissioner, are justified by special circumstances or the unique character of the policy.

(2) *Exclusions pertaining to hospital or basic coverage and major medical policies.* Other exclusions shall include the following:

(i) Eye examinations, refractions, eye glasses, contact lenses or hearing aids or hearing examinations.

(ii) Services, use of a facility or supply which is not recommended or approved by a licensed medical practitioner practicing within the scope of his license.

(iii) Charges for services, use of facilities or supplies that neither the insured nor any other covered person is legally obligated to pay.

(iv) Routine physical examinations.

(v) Dentistry, dental x-rays or dental services, dental prosthetic appliances, except expenses otherwise covered on account of accidental bodily injury to sound natural teeth.

(vi) Expenses of a covered person for cosmetic surgery, except expenses otherwise covered which are necessary for repair of an accidental bodily injury.

(vii) Elective surgery not to exceed 6 months. The following is a list of surgical procedures which may be considered elective surgery:

(A) Cataract operations
(B) Strabismus operations
(C) Tonsilectomies, adenoidectomies
(D) Herniotomies
(E) Arthrotomies
(F) Hemorrhoidectomies
(G) Laminectomies
(H) Varicose veins
(I) Gall bladder
(J) Appendectomies concurrent with a gall bladder operation.

(viii) Expenses for transportation except local ambulance service for the insured or covered person.

(ix) Sickness or injuries to the extent that any covered person under the policy is indemnified by ''Medicare'' for the expenses incurred. This exclusion may include other specifically enumerated national, state or other governmental plans. It may not include or be interpreted to include plans which may possibly be enacted at some future time.

(x) Services performed by the insured's spouse, child, parent, brother or sister or persons who ordinarily reside in the insured's household.

(xi) Medical care of members of the armed forces in a United States Government facility.

(xii) Specified foot conditions.

(b) A policy which contains unusual limitations, reductions or conditions of a restrictive nature that the payment of benefits under the policies is limited in frequency or in amounts should carry the legend ''This Is A Limited Policy—Read It Carefully'' imprinted in not less than 18-point outline type of contrasting color diagonally across the face and filing back, if any, of the policy.

(c) A policy may not provide an exclusion for the use of alcohol and narcotics except as permitted by section 618(b)(11) of the act (40 P. S. § 753(b)(11)).

Notes of Decisions

Applicability limited

The exclusions and other provisions of § 89.77 apply only to individual policies and not to group policies. *Giangreco v. United States Life Ins. Co.*, 168 F. Supp. 2d 417 (E.D. Pa. 2001).

Sections 89.77(a)(2)(ix) and 89.97(c) evidence a public policy favoring the use of policy clauses to prevent overinsurance and avoid bonus recoveries. *Weiss v. CNA,* 468 F. Supp. 1291 (W.D. Pa. 1979).

(286018) No. 328 Mar. 02

§ 89.78. Multiple benefits.

(a) Policies which contain multiple benefits should not limit the payment of a specific benefit based on the fact that another benefit is paid under the same policy.

(b) Examples of the policies that the Department considers unacceptable are policies containing both disability income benefits and hospital or other medical care benefits in which payment of hospital or medical care benefits is excluded if disability income is payable, policies which contain accidental death benefits and medical care or disability benefits which limit the benefit payable to one of the two benefits, policies which contain lump sum dismemberment benefits which are paid in lieu of disability income or medical expenses benefits.

§ 89.79. Accident policies not providing coverage for sickness.

In accident only policies, continuous 24-hour coverage as well as all causes should be provided.

§ 89.80. Loss of time benefits.

(a) Loss of time policies may not require that the loss from accidental injury commence within less than 30 days after the date of an accident, nor may the accident policy which the insurer may cancel or refuse to renew require that it be in force at the time the loss commences.

(b) A policy of health and accident insurance will not be approved which contains a provision that the disability period shall be considered to commence with the date on which written notice is actually received by the company.

(c) Policies which limit benefits for loss of time to specified items, such as business overhead policies, shall provide for a premium refund in accordance with a short rate table in the event that none of the items to be indemnified exist at the time the policy is cancelled, for example, where a professional person discontinues his office, but only if the insured requests cancellation of the policy and gives timely notice. A premium refund may be limited to 1 year's premium.

(d) The definition of total disability should be sufficiently clear so as not to confuse or mislead the insured. Wording in the definition of total disability should be that claim administration will be uniform as possible and the coverage is in the best interests of the insurance buying public.

(e) A provision for accidental death benefit may not contain a requirement that death must occur within a specific time period.

Source

The provisions of this § 89.80 amended June 23, 1978, effective June 24, 1978, 8 Pa.B. 1678. Immediately preceding text appears at serial page (21915).

§ 89.81. Riders and endorsements.

Transfer riders which eliminate waiting periods in time limit on certain defenses or preexisting conditions may be approved for an exchange of policies within a company or affiliated companies but not in transfer from one company to another.

§ 89.82. Miscellaneous policy provisions.

(a) If the policy provides for a reduction in benefits because of the attainment of a specified age limit, reference thereto shall be set forth on the first or specifications page. For this purpose, a reduction in a benefit period is a reduction in benefits requiring such reference.

(b) Policies shall comply with section 617 of the act (40 P. S. § 752), providing for the continuation of coverage for mentally retarded and physically handicapped dependents.

(c) A policy which contains a disability income benefit or a similar type benefit may not require an insured person to be confined to his residence due to sickness or injury as a condition for the benefit, a change in the amount of the benefit or a change in duration of coverage of the benefit.

(d) A reduction of benefits by reason of a change in employment status or change in income of the insured may be permitted, unless clearly set forth in the policy under an appropriate caption.

(e) Dependency status may not be defined by sex.

§ 89.83. Rates.

(a) *General.* Accident and health insurance rate filings will be examined for actuarial adequacy, consistency and equity, including nondiscrimination aspects. Data required should be broken down by the type of filing as prescribed in subsections (b) and (c). The Department will consider in its rate review, along with other pertinent data, the loss ratios submitted by companies as anticipated to be accumulated over the entire period of coverage.

(b) *New filings.* New filings shall conform with all of the following:

(1) With regard to rates for policies which are initially filed for approval, the Department will not consider acceptable anticipated loss ratios which are lower than the following levels:

Type	*Percentage*
Industrial policies	45
All other policies	50

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(2) The company shall maintain its records in a condition that loss ratios may be traced on a closed block basis for each calendar year, thus yielding durational loss ratios relative to a given calendar year of underwriting.

(3) New filings shall also conform with all of the following:

(i) An actuarial memorandum shall be submitted describing how premium rates were computed. The memorandum shall include suitable data indicating the basis for the rates, such as the expected claim costs, the tables or experience, if any, upon which the rates have been based, and an explanation of how the premium rates were obtained.

(ii) If modifications have been based on judgment, this should be indicated as well as any other relevant information which the company considers appropriate.

(iii) Rates shall be adequate but not excessive, provide for internal equity, and be consistent with rates for any concurrent coverage available.

(c) *Revision of current rates.* Revision of current rates shall conform with the following:

(1) With regard to rate revision, the following minimum loss ratios shall be used in establishing an appropriate level of rate increases:

Type	*Percentage*
Industrial policies	50
All other policies	60

(2) Where revision of current rates is involved, benefits should be described, a copy of the appropriate form should be attached and all of the following data shall be furnished:

(i) A statement as to the reason for the revision, the nature of the revision, the detailed areas revised, existing rates, revised rates, the percentage increase or decrease in each rating category and an estimate as to the expected average aggregate increase or decrease in premiums, the recent experience under existing rates showing premiums on both a written and earned basis and showing losses on both a paid and incurred basis.

(ii) If rate increases are not substantial in amount or percentage and there are no unusual re-rating features, the statement required by subsection (a) shall normally suffice in conjunction with completed rate sheets in dollar amounts for categories submitted in duplicate. If, however, rating revisions are substantial, the Department may request any or all of the following information:

(A) Details as to dollar amounts, percentage increases and the effective date of the last increase.

(B) Commission scales by duration and additional expense allocations which are available in the records of the company and are deemed appropriate for purposes of determining surplus strain.

(C) The following data for every rating category, both nationwide and for this Commonwealth:

(I) Premiums written and derivation of premiums earned from changes in unearned premiums and active life reserves. Explicit details as to the type of reserve and basis of its calculation should be supplied for any amounts designated as ''held in reserve.'' Whether these are accrued claim liabilities or active life reserves or contingency reserves should be specified and a general statement should be made as to the basis of calculation.

(II) Claims paid and derivation of claims incurred from accrued claim liabilities identifying reported and unreported accruals separately. Cash, incurred and supplemental loss ratios should be computed. A loss ratio analysis available by duration should be supplied. If separate figures for this Commonwealth are not available, estimates as to amounts applicable in this Commonwealth should be made.

(D) The Department will examine requests for rate increases on an individual basis as appropriate. It is realized that there are many factors relative to a determination of a reasonable loss ratio for a given coverage. Some of the factors are type of coverage, level of premiums, loss ratio trends, modal expenses, active life and claim reserves as they pertain to rate increases, statistical significance of experience figures in each rating category, previous history of dividend distribution and absolute size of the most recent loss ratios. A minimum experience period of 3 years will be required prior to the approval of a substantial rate increase.

(iii) Data submitted for rate revision should be in agreement with annual statement data filed with this Department.

(d) *Filing procedure.* Proposed rate sheets shall be filed in duplicate on 8 1/2 by 11-inch sheets with the name and address of the company appearing on the rate sheet, unless submitted in notebook form.

§ 89.84. Discrimination prohibited.

No discrimination in availability of policy forms or other restrictions or limitations in underwriting practices or eligibility standards are permitted on the basis of race, religion, nationality or ethnic group, age, sex, family size, occupation, place of residence or marital status in accordance with section 5(a)(7)(III) of the Unfair Insurance Practices Act (40 P. S. § 1171.5(a)(7)(III)) and PA. CONST. art. I, § 7.

(214560) No. 260 Jul. 96

§ 89.85. Severability.

If a provision of this chapter or the application thereof to a person is held invalid, the remainder of the chapter and the application of the provision to other persons will not be affected thereby.

GROUP POLICIES

§ 89.91. General filing requirements.

(a) *Conformity to definition.* A group life policy issued for delivery in this Commonwealth will not be approved by the Department which does not apply to a group filing within the definition of a group qualified for the insurance under the act of May 11, 1949 (P. L. 1210, No. 367) (40 P. S. §§ 532.1—532.7a), known as the Group Life Insurance Policy Laws. If an element of doubt exists as to whether a particular group is one authorized by the statute, the question shall be referred to the Department for review in advance of filing.

(b) *Identification of insured.* Group life and annuity certificates filed with the Department shall provide for the identification of the insured. This may be accomplished by having the name of the insured stated on the certificate or a code which could be used in the identification of the certificate holder.

(c) *Variations in policies.* Group life policies, their certificates and the intended insert pages reflecting possible variations shall be accepted for approval, provided that the filing is accompanied by a statement showing the combinations of pages which shall be used for the different types of policies.

(d) *Certificates.* Certificates shall conform with all of the following:

(1) Certificates shall be issued to the policy owner within a reasonable period of time after issuance of the master policy for delivery to each person insured.

(2) Certifying language shall be used in certificates.

(3) Certificates should state the benefits applicable to the person insured or state the schedule of benefits applicable to the class to which he belongs.

§ 89.92. Use of certain words and terms.

Policies which are to be issued to supplement or implement Medicare may not have policy titles or headings which could confuse them with the Federal Medicare Program.

§ 89.93. Termination of policy.

(a) Master policies, riders and certificates shall contain a clear explanation as to continuance of that coverage after termination of the policy. In the case of maternity benefits, the policy shall clearly define the circumstances under which the coverage ceases and whether the insurer intends to include a pregnancy coverage for 9 months after the policy has expired or whether the coverage ceases with the expiration of the remainder of the policy.

(b) A group accident and health policy may not contain a provision for automatic termination of the coverage of an individual upon the happening of a loss, except a loss which has exhausted all possible benefits under the policy.

§ 89.94. Exclusions.

Exclusions which are ambiguous or unfairly discriminatory are not acceptable.

Notes of Decisions

Ambiguous Provision

Insurer's policy which excludes from coverage persons who are ''totally disabled'' is ambiguous, and, therefore, must be construed against insurer. *Schneider v. UNUM Life Insurance Co. of America*, 149 F. Supp.2d 169 (E.D. Pa. 2001).

Exclusions Limited

Only exclusions which are ambiguous or unfairly discriminatory are prohibited in group policies. Other limitations, which are barred from individual policies, do not apply to group policies. *Giangreco v. United States Life Ins. Co.*, 168 F. Supp 2d 417 (E.D. Pa. 2001).

Construction

In the absence of any statutory language or administrative rulings which interpret the meaning of the term ''ambiguous'' in a regulation, the court looks to the plain meaning of the term. The meaning of the term ''ambiguous'' as defined in *Northbrook Ins. Co. v. Kuljian Corp.*, 690 F. 2d 368, 372 (3d Cir. 1982), is consistent with the plain meaning of that term as set forth in 31 Pa. Code § 89.94. *Schneider v. UNUM Life Insurance Co. of America*, 149 F. Supp. 2d. 169 (Pa. 2001); declined to follow 162 F. Supp. 1119 (C. D. Cal. 2001).

Nonpreemption under ERISA

The State insurance regulation section which prohibits ambiguous or discriminatory policy provisions is a law which regulates insurance, thereby excluding that section from ERISA preemption. An insured may bring an action for violation of that section, even if the coverage is provided as part of an employee's ERISA benefit plan. *Schneider v. UNUM Life Insurance Co. of America*, 149 F. Supp.2d 169 (E.D. Pa. 2001).

§ 89.95. Loss of time benefits.

Loss of time benefits for dependents are not acceptable.

§ 89.96. Certificates.

(a) Certifying language shall be used in certificates.

(b) Certificates shall be issued to the policy owner within a reasonable period of time after the effective date of the master policy for delivery to each person insured. Certificates should state the benefits applicable to the person insured or state the schedule of benefits applicable to the class to which he belongs.

§ 89.97. Miscellaneous policy provisions.

(a) *Conformity with definition of a group.* A group policy of insurance approved by the Department will not be issued for delivery in this Commonwealth by an insurer to a group which does not come within the definition of a group qualified for the insurance.

(b) *Variations in policies.* Because of the many variations possible in group accident and health policies, the policies, their certificates and the intended insert pages reflecting possible variations will be accepted for approval, provided that the filing is accompanied by a statement showing the combination of pages which

will be used for different types of policies.

(c) *Coordination with other plans.* Nonduplication or coordination of benefit provisions for group medical expense insurance coverages may provide for nonduplication or coordination with a plan or State or Federal program providing benefits or services for or by reason of medical or dental care and treatment which benefits or services are provided by group insurance or another arrangement of coverage of persons in a group whether on an insured or uninsured basis. Policies with these provisions shall stipulate clearly how the provisions will be administered.

(d) *Accidental death benefit.* A provision for accidental death benefit may not contain a requirement that death must occur within a specific time period.

Source

The provisions of this § 89.97 amended June 23, 1978, effective June 24, 1978, 8 Pa.B. 1678. Immediately preceding text appears at serial page (13326).

(284864) No. 326 Jan. 02

Notes of Decisions

Public Policy

This section and § 89.77(a)(2)(ix) evidence a public policy favoring the use of policy clauses to prevent overinsurance and avoid bonus recoveries. *Weiss v. CNA,* 468 F. Supp. 1291 (W.D. Pa. 1979).

§ 89.97a. Maternity benefits in group converted policies—statement of policy.

(a) Section 621.2 of the act (40 P. S. § 756.2(d)) mandates that every group accident and sickness policy providing hospital, surgical or major medical expense coverage contain a conversion privilege. The converted policy may not contain provisions less favorable to the insured than the group policy.

(b) An insurer shall offer a converted policy which includes maternity coverage whenever the group policy contains the coverage. Insurers not offering maternity benefits in converted policies under these circumstances are in violation of Commonwealth law and shall make form and rate filings necessary to comply.

Source

The provisions of this § 89.97a adopted April 9, 1982, effective April 10, 1982, 12 Pa.B. 1176.

§ 89.98. Major medical.

In the event of termination of insurance because of termination of active employment, a reasonable extended benefit should be provided during total disability, with respect to the sickness or injury which caused the disability, of at least 12 months subsequent to termination of insurance, unless coverage is afforded for total disability under another group plan.

§ 89.99. Student accident and sickness insurance.

(a) An application, enrollment form, policy, certificate or brochure used in lieu of a certificate, rider or endorsement may not be used, sold or issued until the forms of the same have been filed with and approved by the Insurance Commissioner.

(b) Applicable premium rates shall be filed with the Department.

(c) The insurer shall make known to every individual purchaser the applicable schedule of benefits, premium rates and claim filing procedures and advise where additional information and assistance relating to the benefits, rates and procedures may be obtained.

(d) Certificate or brochure used in lieu of a certificate shall set forth the essential features of the coverage, location of the claims office and instructions for filing claims and it shall be delivered or furnished for delivery to the individual purchaser.

(e) A provision excluding, limiting or coordinating benefits by reason of other insurance shall be set forth clearly in the policy, be accurately summarized

in a certificate or brochure used in lieu of a certificate and in advertising material, and not be applied to the first $100 of any one claim.

(f) Prior to its initial use, material used in the direct solicitation of student accident insurance shall be submitted to the Department for review. Within 30 days from the date that the material is received by the Department, the insurer will be notified whether or not the Department has an objection to the same. Thereafter, amended material shall be promptly submitted to the Department; however, review prior to use will be required only in the event of substantial change.

(g) Advertising material and direct solicitation material prepared by an agent or broker shall be approved by the insurer prior to use. Material which differs substantially from that already submitted by the insurer to the Department for review shall be submitted under subsection (f).

(h) The insurer shall require an enrollment form to be signed by the parents, guardian or person in loco parentis of each student, except in the case of married or adult students, or where the participant is not required to make a premium contribution.

(i) An individual application or enrollment form shall clearly indicate that there is no obligation to purchase the insurance.

Source

The provisions of this § 89.99 adopted October 23, 1970, effective October 24, 1970, 1 Pa.B. 435.

Subchapter D. ADDITIONAL REQUIREMENTS FOR FRATERNAL BENEFIT SOCIETIES

Sec.

Source

The provisions of this Subchapter D amended May 16, 1975, effective May 17, 1975, 5 Pa.B. 1299, unless otherwise noted.

§ 89.101. Prior approval of forms required.

Under 40 Pa.C.S. § 6529(c) (relating to beneficiary certificates), it is unlawful for a fraternal benefit society to issue, sell or dispose of a certificate or contract providing benefits to its membership in this Commonwealth or use applications, riders or endorsements in connection therewith, until the forms thereof have been submitted to and approved by the Department.

§ 89.102. Guidelines for approval of forms.

(a) *General filing requirements.* Fraternal benefit society filings shall comply with the requirements and procedures of Subchapters A—C (relating to requirements for all policies and forms; requirements for life insurance; and requirements for accident and health insurance) except where these requirements and procedures are not applicable.

(b) *General conditions of approval.* General conditions of approval shall conform with the following:

(1) An approved form may not be used to insure anyone who is not a member or a spouse or dependent of a member of the fraternal benefit society as required by section 301(b) of the Fraternal Benefit Society Code (40 P. S. § 1141-301(b)). Nor may an approved form be used to insure a juvenile except upon the application of an adult as required by section 302(a) of the Fraternal Benefit Society Code (40 P. S. § 1141-302(a)).

(2) [Reserved].

(3) Forms can contain words such as insurance, insured, premium, policy and other type words usually associated with commercial insurance. In lieu thereof, words such as benefit, member, dues, certificate and the like type may be used. However, the type of wording used in forms shall be consistent. This is not intended to prohibit the use of words to describe different things as long as the wording used in the form is consistent.

(4) Approvals are conditioned upon the forms being used lawfully, and in conformity with applicable rules and regulations of the Department.

(c) *Specific guidelines for certificates.* Specific guidelines for certificates shall conform with the following:

(1) The words ''A Fraternal Benefit Society'' will appear in conspicuous type on the first page and filing back under the name of the society, as required by section 403 of the Fraternal Benefit Society Code (40 P. S. § 1141-403).

(2) If a certificate is issued on the life of a nonmember as the principal insured, the following or similar terminology shall appear in the certificate:

(i) If a certificate is issued in connection with section 301(b) of the Fraternal Benefit Society Code (40 P. S. § 1141-301(b)) it shall contain the following:

Application Member _____

Insured _____

(ii) If a certificate is issued in connection with section 302(a) of the Fraternal Benefit Society Code (40 P. S. § 1141-302(a)) it shall contain the following:

Applicant Adult _____

Insured _____

(3) A certificate shall provide a suspended or expelled member with the opportunity to maintain his certificate or his spouse's or dependent's certificate in force, upon timely payment of premium.

(4) A certificate shall specify (except with respect to those excluded by section 903 of the Fraternal Benefit Society Code (40 P. S. § 1141-903) the amount of benefits furnished thereunder. A certificate shall provide that the certificate, charter or articles of incorporation or, if a voluntary association, the articles of the association, the constitution and bylaws of the society, the application for membership, medical examination or health certificates signed by the applicant and amendments to the documents, shall constitute the agreement between the society and the member. See section 306(a) of the Fraternal Benefit Society Code (40 P. S. § 1141-306(a)).

(5) In order that the membership may be fully aware of their responsibility, certificates shall provide, except with respect to those excluded by section 903 of the Fraternal Benefit Society Code (40 P. S. § 1141-903) for additional or increased contributions from members in the event of financial deficiencies to the extent required in the bylaws and shall provide for the consequences if the contributions are not made.

(6) A certificate providing an accidental death benefit may not contain a requirement that death must occur within a specific time period.

(d) *Specific guidelines for applications.* Specific guidelines for applications shall conform with the following:

(1) Membership and insurance applications may not be combined into one application. Questions relating to membership may not be included in an insurance application, except as provided in paragraph (5).

(2) If proposed insured is adult (18 or over), a member, and is the applicant, the application for insurance shall contain:

''Proposed Insured's Signature _____''

(3) If proposed insured is an adult and not a member, the application for insurance shall contain:

''Proposed Insured's Signature _____''

''Member Applicant's Signature _____''

(4) If proposed insured is a child, the application for insurance shall contain:

''Adult Applicant's Signature _____''

(5) Each application except exchange or conversion applications for insurance on the life of an adult shall contain the following:

''Is the applicant a member of (_____)?''

''Yes ____ No ____''

''If not, apply for membership.''

(6) The words ''A Fraternal Benefit Society'' shall appear in conspicuous type on the insurance application.

Source

The provisions of this § 89.102 amended July 22, 1977, effective July 23, 1977, 7 Pa.B. 2060. Immediately preceding text appears at serial page (19984).

Cross References

This section cited in 31 Pa. Code § 90c.23 (relating to applications of fraternal benefit societies); 31 Pa. Code § 90d.8 (relating to fraternal benefit society); 31 Pa. Code § 90e.10 (relating to fraternal benefit society); 31 Pa. Code § 90f.12 (relating to fraternal benefit society); 31 Pa. Code § 90g.12 (relating to fraternal benefit society); and 31 Pa. Code § 90h.10 (relating to fraternal benefit society).

§ 89.103. Advertising.

(a) Advertising used in connection with approved forms shall prominently disclose that the insurance is available only to members, their spouses and dependents, or to juveniles.

(b) The insurance solicitation shall be segregated from the membership solicitation in advertising simultaneously soliciting insurance and membership.

§ 89.104. Charter, bylaws and rate books.

A certified and current copy of the charter and bylaws of the society and rate book shall be filed with the Bureau of Regulation of Rates and Policies.

Subchapter F. COVERAGE FOR NEWBORN CHILDREN

Sec.
89.201. Definitions.
89.202. Forms which need not provide newborn coverage.
89.203. Forms which must provide newborn coverage.
89.204. Inapplicability of preexisting condition limitation or waiting period limitation.
89.205. Compliance procedure.
89.206. Filing procedure.
89.207. Rates.
89.208. Deferred claims.
89.209. Retroactive compliance provisions.

Authority

The provisions of this Subchapter F issued under The Insurance Company Law of 1921 (40 P. S. §§ 341—991); The Insurance Department Act of 1921 (40 P. S. §§ 1—321); and sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412), unless otherwise noted.

Source

The provisions of this Subchapter F adopted September 5, 1976, effective September 6, 1976, 6 Pa.B. 2107, unless otherwise noted.

§ 89.201. Definitions.

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

Act 81—The act of August 1, 1975 (P. L. 157, No. 81) (40 P. S. §§ 753.1—753.4).

Coverage for newborn children—The same coverage provided under the terms of the form for dependent children for sickness, disease or injury. If the form does not provide coverage for dependent children, the coverage shall be the same as that provided the insured or subscriber. For purposes of compliance with Act 81, injury or sickness shall include medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. If the form provides coverage for routine well baby care, the same coverage shall be provided for newborn children. The coverage shall be provided regardless of whether the form provides for obstetrical coverage.

Insured or subscriber—A person, male or female, covered under the terms of a form to which Act 81 is applicable, regardless of the covered person's marital or dependency status or eligibility for maternity benefits.

Routine nursery care—Hospital or other qualified health care institution, room, board or miscellaneous institutional care or care rendered by a licensed medical practitioner, performing within the scope of his license, associated with hospital confinement.

Routine well-baby care—Expense for which coverage is available under a form to a covered person for preventive health care, rendered either on an inpatient or outpatient basis, not associated with treatment of an ill or injured person, such as, but not limited to, immunizations, medical examinations or tests not necessary for the treatment of covered injuries, illnesses, birth defects, deformities or diseases, and hospital room, board or miscellaneous institutional expenses.

§ 89.202. Forms which need not provide newborn coverage.

Forms of insurers, other than hospital plan corporations, professional health service plan corporations, fraternal benefit societies and voluntary nonprofit health service plans, providing benefits on an indemnity basis, for example, payment on a specified amount without regard to actual expense incurred, need not provide coverage for newborn children.

§ 89.203. Forms which must provide newborn coverage.

(a) Forms providing benefits on an expense incurred or service basis shall extend the benefits to newborn children.

(b) Where a form provides both expense incurred or service benefits and indemnity benefits, for the purposes of implementation of Act 81 and this subchapter, the policy shall be considered an expense incurred or service benefit

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policy, and benefits thereunder shall be extended to newborn children. Accidental death or accidental death and dismemberment or disability income benefits need not be extended to newborn children, even though the form provides some expense incurred benefits.

§ 89.204. Inapplicability of preexisting condition limitation or waiting period limitation.

A form may not deny a claim for newborn coverage on the basis that the cause of the claim was a sickness or injury which existed on or prior to the effective date of the coverage or date of birth of the newborn. A form may not provide for a waiting period between the date of birth and provision of coverage for a newborn child, unless the waiting period is applicable to all insureds under the form, that is, the form provides coverage from the fourth day of hospitalization due to sickness, provided however, that upon newly issued forms a company, in order to prevent adverse selection against it by persons who may seek to buy coverage solely to have a newborn covered, may impose a limitation that the newborn child shall have been conceived on or after the effective date of coverage of the form.

§ 89.205. Compliance procedure.

Forms issued or renewed on or after November 29, 1975, shall provide at least the coverage specified in Act 81 as interpreted by this subchapter, either by amendatory rider or endorsement or appropriate revision of the form itself.

(1) The form provision shall provide that the newborn child coverage is included automatically for each newborn child for 31 days after birth and that the insured or subscriber shall have the right upon application if such is required by the insurer within the 31 day period to continue coverage beyond the 31 day period if the form provides for coverage of dependents.

(2) If the form does not provide for coverage of dependents, the insured or subscriber shall have the right, upon application within 31 days of the birth of the newborn, to convert to a form which shall provide substantially similar benefits, or to add an appropriate coverage rider to the existing form.

§ 89.206. Filing procedure.

(a) Insurers subject to Act 81 and this subchapter shall submit for review and approval compliance riders or endorsements to affected, currently approved and in-use forms.

(b) Prior to January 1, 1977, required changes in forms submitted for review and approval may contain required Act 81 amendments by an amendatory rider, or the changes may be incorporated into the text of the new or revised policy submission. After that date, contracts submitted for review and approval shall contain Act 81 compliance provisions within the text of the form itself. A form submission made prior to January 1, 1977, should specify within its submission letter how Act 81 has been or will be complied with in the form so submitted.

§ 89.207. Rates.

A necessary and appropriate change in currently approved premium rates required by the 31 day newborn coverage period extension shall be submitted for review and approval in accordance with applicable statutory authority.

§ 89.208. Deferred claims.

Coverage for claims incurred during the 31 day newborn coverage period, extending beyond the period in those cases wherein no valid application for continuation of coverage is made on behalf of the newborn, shall be covered in accordance with the termination provisions otherwise applicable to other covered members.

§ 89.209. Retroactive compliance provisions.

(a) An insurer shall provide affected insureds with a compliance rider, which shall be retroactively effective to November 29, 1975, or a later form renewal date that may be applicable.

(b) An insurer shall retroactively evaluate claims arising on or after November 29, 1975, for applicability of Act 81 and this subchapter in claims settlement.

Subchapter G. PREEXISTING CONDITION EXCLUSION IN GROUP CONTRACTS

Sec.

Source

The provisions of this Subchapter G adopted August 4, 1978, 8 Pa.B. 2182, effective date postponed until further notice January 26, 1979, 9 Pa.B. 314, unless otherwise noted.

§ 89.401. Scope.

This subchapter applies to:

(1) Policies of group accident, group sickness or group accident and sickness insurance policies, as defined in section 621.2 of the act (40 P. S. § 756.2), issued or issued for delivery in this Commonwealth.

(2) Policies of blanket accident and sickness insurance, as defined in section 621.3 of the act (40 P. S. § 756.3) issued or issued for delivery in this Commonwealth.

(3) Group master agreements issued by a hospital plan corporation subject to the prior approval of the Department under 40 Pa.C.S. § 6124 (relating to rates and contracts).

(4) Group master agreements issued by a professional health services plan corporation subject to the prior approval of the Department under 40 Pa.C.S. § 6329 (relating to rates and contracts).

(5) Blanket or group student accident sickness insurance and group mortgage disability insurance policies subject to the prior approval of the Department under section 621.2 of the act (40 P. S. § 756.2) issued or issued for delivery in this Commonwealth.

Source

The provisions of this § 89.401 amended August 24, 1979, effective November 23, 1979, 9 Pa.B. 2891. Immediately preceding text appears at serial pages (39799) to (39800).

Cross References

This section cited in 31 Pa. Code § 89.407 (relating to effective date).

§ 89.402. Approval.

(a) A preexisting condition limitation will not be approved for use with a policy or contract which is more restrictive than the following definition: A preexisting condition is a disease or physical condition for which medical advice or treatment has been received within 90 days immediately prior to becoming covered under the group contract. The condition shall be covered after the individual has been covered for more than 12 months under the group contract.

(b) Long-term disability benefit provisions may require that the total disability resulting from a preexisting condition commence after the individual has been covered for more than 12 months under the group contract.

Source

The provisions of this § 89.402 amended August 24, 1979, effective November 23, 1979, 9 Pa.B. 2891. Immediately preceding text appears at serial page (39800).

Cross References

This section cited in 31 Pa. Code § 89.404 (relating to preexisting condition).

§ 89.403. Disclosure.

(a) A disclosure statement substantially similar to the following shall be given in writing to a group member at the time of the enrollment under the group contract.

NOTICE

If you or any dependents have received medical care or advice within the past 90 days for a disease or physical condition, you, he or she will not be covered for such disease or physical condition until you, he or she has been covered for one year under this contract. This exclusion, however, only applies to a disease or physical condition for which medical care or advice has been received in the past 90 days.

(b) The statement set forth in subsection (a) shall be printed in bold face type.

Authority

The provisions of this § 89.403 issued under The Insurance Company Law of 1921 (40 P. S. §§ 1—321); The Insurance Company Law of 1921 (40 P. S. §§ 341—991); sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and 40 Pa.C.S. §§ 6124 and 6329.

Source

The provisions of this § 89.403 amended through June 27, 1980, effective June 28, 1980, 10 Pa.B. 2591. Immediately preceding text appears at serial page (42687).

§ 89.404. Preexisting condition.

A preexisting condition limitation defined other than as set forth in § 89.402 (relating to approval) shall substantially conform to the standards set forth in this subchapter. The preexisting condition limitation would be considered for approval by the Department only upon appropriate justification by the submitting company proposing to use it.

§ 89.405. Exclusion.

(a) Every group contract issued to a policyholder to replace another group contract shall only exclude a preexisting condition excluded by the other group policy.

(b) The provisions of subsection (a) applies to those individuals covered under the group policy being replaced.

Source

The provisions of this § 89.405 amended August 24, 1979 effective November 23, 1979, 9 Pa.B. 2891. Immediately preceding text appears at serial page (39801).

§ 89.406. Acceptability.

A preexisting condition exclusion will not be acceptable in blanket or group student accident and sickness insurance and group mortgage disability insurance.

§ 89.407. Effective date.

This subchapter applies to policies and agreements set forth in § 89.401 (relating to scope) issued, renewed, substantially altered or amended, on or after November 23, 1979.

Source

The provisions of this § 89.407 amended August 24, 1979, effective November 23, 1979, 9 Pa.B. 2891. Immediately preceding text appears at serial page (39801).

Subchapter H. STATEMENTS OF POLICY

GENERALLY

Sec.
89.451. Insurance coverage.
89.461. Fraternal benefit societies.

STOP-LOSS POLICIES

89.471. Licensed accident and health insurers may write stop-loss coverage.
89.472. Filing requirements for stop-loss policies.
89.473. Ascertaining the legitimacy of the underlying plan.
89.474. Prohibited activities.

GENERALLY

§ 89.451. Insurance coverage.

The act of December 23, 1981 (P. L. 583, No. 168) (40 P. S. §§ 3001—3003) requires that the services of licensed midwives be covered on the same basis as the services of licensed physicians or osteopaths for those areas of practice for which midwives may be licensed. Effective February 6, 1982, no policy form, subscriber agreement or certificate will be approved by the Insurance Department unless it complies with the act of December 23, 1981 (P. L. 583, No. 168) (40 P. S. §§ 3001—3003).

Source

The provisions of this § 89.451 adopted February 5, 1982, effective February 6, 1982, 12 Pa.B. 797.

§ 89.461. Fraternal benefit societies.

Section 3101(d) of 20 Pa.C.S. (relating to payments to family and funeral directors) was amended to allow for direct payment to certain statutorily determined recipients of an insurance contract for an amount of $11,000 or less where

an appointed personal representative of the decedent has failed to make written demand for payment within 60 days following the death of the insured. The Department construes the insurance contracts specified in 20 Pa.C.S. § 3101(d) to include insurance contracts offered by fraternal benefit societies which are regulated by the Department under the Fraternal Benefit Societies Code (40 P. S. §§ 1141-101—1141-1001).

Source

The provisions of this § 89.461 adopted January 13, 1983, effective January 15, 1983, 13 Pa.B. 464.

STOP-LOSS POLICIES

§ 89.471. Licensed accident and health insurers may write stop-loss coverage.

(a) Section 202 of the act (40 P. S. § 382), defines group accident and health coverages that may be written by licensed accident and health companies. In an effort to increase health insurance options available to employers, stop-loss; that is, excess loss, coverage may be written by Pennsylvania licensed accident and health companies, if, before doing so, the Department has determined that the policy serves the interests of the public, and has approved the policy.

(b) This coverage may still be written by property and casualty insurers, if they also have the authority to write accident and health insurance. Current, approved policies written by property and casualty insurers may continue in force.

Source

The provisions of this § 89.471 adopted September 25, 1992, effective September 26, 1992, 22 Pa.B. 4785.

§ 89.472. Filing requirements for stop-loss policies.

(a) Section 354 of the act (40 P. S. § 477b), authorizes the Department to review and approve accident and health policies filed by companies. A stop-loss policy submitted to the Department for approval shall satisfy the following conditions:

(1) The stop-loss policy shall be issued to, and insure, the sponsor of the plan, or the plan itself, not the employes, members or participants.

(2) Payments by the insurer shall be made to the sponsor of the plan or the plan itself, not the employes, members, participants or providers.

(3) The individual stop-loss amount; that is, retention or attachment point per claimant, shall be at least $10,000; the aggregate stop-loss amount for the plan shall be, at a minimum, $100,000 per calendar year.

(4) The stop-loss policy shall contain a provision that the plan's or the plan sponsor's bankruptcy or insolvency will not relieve the stop-loss carrier from its obligation to pay claims under the stop-loss policy.

(5) In addition to the stop-loss policy filed with the Department for approval, filings shall contain a separate document certifying that each of the four requirements listed in paragraphs (1)—(4) have been met.

(b) Stop-loss is not equivalent to reinsurance; reinsurance only relates to transactions between commercial insurers. An entity purporting to cover self-insured plans will be treated as a stop-loss insurer and will be subject to insurance laws and regulations of the Commonwealth relating thereto and penalties for violations thereof.

(c) If the original self-funded employe benefit plan is exempt from providing State mandated health benefits; that is, if the underlying plan is ERISA exempt, the stop-loss policy should not provide more benefits than the original policy, absent an agreement to the contrary between the employer and the stop-loss insurer. If the stop-loss policy covers excess benefits on an underlying policy or plan which is not ERISA exempt and thus provides State mandated benefits, the stop-loss policy shall include State mandated benefits.

Source

The provisions of this § 89.472 adopted September 25, 1992, effective September 26, 1992, 22 Pa.B. 4785.

§ 89.473. Ascertaining the legitimacy of the underlying plan.

(a) *Legitimacy of underlying plan.* Insurance companies writing stop-loss coverage shall exercise due diligence in ascertaining the legitimacy of the underlying plan before issuing coverage. This includes ensuring that:

(1) The underlying plan is a legitimate self-funded plan and not a self-insured or partially insured multiple employer welfare arrangement.

(2) The plan is not structured in a manner that is prohibited by this subsection.

(b) *Pooling of risk prohibited.*

(1) An underlying plan that aggregates multiple employers' funds into an account, trust or other funding vehicle shall be capable of demonstrating that there is no pooling of risk between employers in any manner, including one or more of the following:

(i) Paying one employer's claims from another employer or multiple employers' contributions or premiums.

(ii) Aggregating two or more employers' claims to trigger stop-loss coverage.

(2) In any case, an entity that commingles multiple employers' funds into one account will be subject to scrutiny by the Department and shall be able to demonstrate that each participating employer's claims and contributions are severable.

Source

The provisions of this § 89.473 adopted September 25, 1992, effective September 26, 1992, 22 Pa.B. 4785.

§ 89.474. Prohibited activities.

An individual or entity, including third-party administrators, that places stop-loss coverage through an insurer or other entity not licensed to issue stop-loss coverage in this Commonwealth may be found to be in violation of provisions of The Insurance Department Act of one thousand nine hundred and twenty-one (40 P. S. §§ 1—297.4) that prohibit unlicensed agent activity. Stop-loss coverage may only be issued by licensed Pennsylvania insurers through their licensed agents or brokers. Other entities who receive, or attempt to receive, a fee, commission or other compensation in connection with the issuance of stop-loss coverage may be found to be in violation of provisions of The Insurance Department Act of one thousand nine hundred and twenty-one that prohibit unlicensed insurance activity. Further, stop-loss coverage may only be issued to valid single employer self-funded ERISA qualified plans, unless the Commissioner determines that other plans may be eligible for the coverage.

Source

The provisions of this § 89.474 adopted September 25, 1992, effective September 26, 1992, 22 Pa.B. 4785.

Subchapter I. ALCOHOL ABUSE AND DEPENDENCY BENEFITS

GENERAL

POLICY REQUIREMENTS

COVERAGE FOR TREATMENT SERVICES

GENERAL

§ 89.601. Applicability.

(a) This subchapter implements Article VI-A of the act (40 P. S. §§ 908-1—908-8) relating to mandatory benefits for the treatment of alcohol abuse and dependency.

(b) This subchapter applies to group health or sickness or accident insurance policies providing hospital or medical/surgical coverage and group subscriber contracts for certificates issued by an entity subject to the act, 40 Pa.C.S. Chapters 61 and 63 (relating to hospital plan corporations; and professional health services plan corporations), the Health Maintenance Orgnization Act (40 P. S. §§ 1551—1567) or the Fraternal Benefit Society Code (40 P. S. §§ 1141.101—1141.905).

(c) Every entity that issues the policies, contracts or certificates described in subsection (b) shall submit forms of the contracts in compliance with this subchapter to the Department by May 25, 1988. The obligation to provide alcohol abuse and dependency benefits applies to policies, contracts and certificates issued or renewed on or after December 8, 1986. A policy, contract or certificate is considered renewed on the date of its renewal or, if the contract had no fixed term as of December 8, 1986, on the first anniversary date on or after December 8, 1986.

Authority

The provisions of this § 89.601 issued under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and The Insurance Company Law of 1921 (40 P. S. §§ 341—391).

Source

The provisions of this § 89.601 adopted March 25, 1988, effective March 26, 1988, 18 Pa.B. 1360.

POLICY REQUIREMENTS

§ 89.611. Deductibles and copayments.

(a) *Definition.* A course of treatment shall be considered to be the full range of detoxification, treatment and supportive services carried out specifically to alleviate the dysfunction of the insured or subscriber.

(b) *First instance or course of treatment.* In the first instance or course of treatment for alcohol abuse and dependency, no deductible or copayment may be

less favorable than those applied to similar classes or categories of treatment for other conditions of physical illness or injury.

(c) *Second and subsequent courses of treatment.* For the second and subsequent courses of treatment for alcohol abuse and dependency, the total proportion of payment after the deductibles and copayments may not be less than 50% of the allowance for similar classes or categories of treatment for other conditions of physical illness or injury.

Authority

The provisions of this § 89.611 issued under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and The Insurance Company Law of 1921 (40 P. S. §§ 341—391).

Source

The provisions of this § 89.611 adopted March 25, 1988, effective March 26, 1988, 18 Pa.B. 1360.

§ 89.612. Minimum covered services.

(a) Nonhospital, residential alcohol treatment services which are included as a covered benefit under Article VI-A of the act (40 P. S. §§ 908-1—908-8) shall be covered for a minimum of 30 days per year. The minimum of 30 days per year may not be exchanged for outpatient alcohol treatment services.

(b) Outpatient alcohol treatment services which are included as a covered benefit under Article VI-A of the act shall be covered for a minimum of 30 outpatient, full-session visits or equivalent partial visits per year. The minimum 30 sessions per year may not be exchanged for nonhospital residential alcohol treatment services.

(c) Thirty outpatient, full-session visits or equivalent partial visits, which may be exchanged on a two-for-one basis for up to 15 nonhospital, residential alcohol treatment days, shall be available in addition to the minimum required in subsections (a) and (b).

(d) Treatment services provided in subsections (a)—(c) may be subject to a lifetime limit, for a covered individual, of 90 days of nonhospital, residential alcohol treatment services and 120 outpatient, full-session visits or equivalent partial visits.

Authority

The provisions of this § 89.612 issued under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and The Insurance Company Law of 1921 (40 P. S. §§ 341—391).

Source

The provisions of this § 89.612 adopted March 25, 1988, effective March 26, 1988, 18 Pa.B. 1360.

COVERAGE FOR TREATMENT SERVICES

§ 89.621. Inpatient detoxification services.

Inpatient detoxification services which are included as a covered benefit under Article VI-A of the act (40 P. S. §§ 908-1—908-8) shall be provided in a facility which meets Department of Health minimum drug and alcohol standards for client-to-staff ratios and staff qualifications and which is one of the following:

(1) A hospital licensed under 28 Pa. Code Chapter 157 (relating to drug and alcohol services) and complying with §§ 157.21—157.25 (relating to inpatient hospital activities—detoxification).

(2) A psychiatric hospital licensed under 28 Pa. Code Chapter 709 Subchapter K (relating to standards for inpatient hospital drug and alcohol activities offered in a freestanding psychiatric hospital) and complying with § 709.122 (relating to detoxification).

(3) A freestanding treatment facility licensed under 28 Pa. Code Chapter 709 (relating to standards for licensure of freestanding treatment facilities) and complying with 28 Pa. Code Chapter 709, Subchapter F (relating to standards for inpatient nonhospital activities—short-term detoxification) and which has a written affiliation agreement with a hospital for emergency, medical and psychiatric or psychological support services.

(4) A health care facility issued a certificate of compliance under 28 Pa. Code Chapter 711 (relating to standards for certification of treatment activities which are a part of a health care facility) and complying with 28 Pa. Code Chapter 711, Subchapter E (relating to standards for inpatient nonhospital activities—short-term detoxification) and which has a written affiliation agreement with a hospital for emergency, medical and psychiatric or psychological support services.

Authority

The provisions of this § 89.621 issued under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and The Insurance Company Law of 1921 (40 P. S. §§ 341—391).

Source

The provisions of this § 89.621 adopted March 25, 1988, effective March 26, 1988, 18 Pa.B. 1360.

§ 89.622. Nonhospital, residential treatment and rehabilitation services.

Nonhospital, residential treatment and rehabilitation services which are included as a covered benefit under Article VI-A of the act (40 P. S. §§ 908-1—908-8) shall be provided in a facility which meets Department of Health minimum drug and alcohol standards for client-to-staff ratios and staff qualifications and which is one of the following:

(1) A freestanding treatment facility licensed under 28 Pa. Code Chapter 709 (relating to standards for licensure of freestanding treatment facilities) and

complying with 28 Pa. Code Chapter 709, Subchapter E (relating to standards for inpatient nonhospital activities—residential treatment and rehabilitation).

(2) A health care facility issued a certificate of compliance under 28 Pa. Code Chapter 711 (relating to standards for certification of treatment activities which are a part of a health care facility) and complying with 28 Pa. Code Chapter 711, Subchapter D (relating to standards for inpatient nonhospital activities—residential treatment and rehabilitation).

Authority

The provisions of this § 89.622 issued under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and The Insurance Company Law of 1921 (40 P. S. §§ 341—391).

Source

The provisions of this § 89.622 adopted March 25, 1988, effective March 26, 1988, 18 Pa.B. 1360.

§ 89.623. Outpatient services.

Outpatient alcohol services which are included as a covered benefit under Article VI-A of the act (40 P. S. §§ 908-1—908-8) shall be provided in a facility which is one of the following:

(1) A freestanding treatment facility licensed under 28 Pa. Code Chapter 709 (relating to standards for licensure of freestanding treatment facilities) and complying with Chapter 709 Subchapter I (relating to standards for outpatient activities).

(2) A psychiatric hospital licensed under 28 Pa. Code Chapter 709.

(3) A health care facility issued a certificate of compliance under 28 Pa. Code Chapter 711 (relating to standards for certification of treatment activities which are a part of a health care facility) and complying with 28 Pa. Code Chapter 711, Subchapter H (relating to standards for outpatient activities).

Authority

The provisions of this § 89.623 issued under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and The Insurance Company Law of 1921 (40 P. S. §§ 341—391).

Source

The provisions of this § 89.623 adopted March 25, 1988, effective March 26, 1988, 18 Pa.B. 1360.

Subchapter J. [Reserved]

Sec.
89.701—89.714. [Reserved].
89.721—89.738. [Reserved].

§§ 89.701—89.714. [Reserved].

Source

The provisions of these §§ 89.701—89.714 adopted September 15, 1989, effective September 16, 1989, 19 Pa.B. 3945; reserved November 30, 1990, effective December 1, 1990, 20 Pa.B. 5921. Immediately preceding text appears at serial pages (142995) to (143017).

§§ 89.721—89.738. [Reserved].

Source

The provisions of these §§ 89.721—89.738 adopted November 30, 1990, effective December 1, 1990, 20 Pa.B. 5921; reserved July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841. Immediately preceding text appears at serial pages (154962) and (154989).

Subchapter K. MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

Sec.
89.751—89.757. [Reserved].
89.761—89.769. [Reserved].
89.770. Purpose.
89.771. Applicability and scope.
89.772. Definitions.
89.773. Policy definitions and terms.
89.774. Exclusions and limitations.
89.775. Minimum benefit standards for policies or certificates issued for delivery prior to July 30, 1992.
89.776. Benefits standards for policies or certificates issued or delivered on or after July 30, 1992, and prior to June 1, 2010.
89.776a. Benefit standards for policies or certificates issued or delivered on or after June 1, 2010.
89.777. 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.
89.777a. Medicare Select policies and certificates.
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.
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.
89.778. Open enrollment.
89.779. Standards for claims payment.
89.780. Loss ratio standards and refund or credit of premium.
89.781. Filing and approval of policies and certificates and premium rates.
89.782. Permitted compensation arrangements.
89.783. Required disclosure provisions.
89.784. Requirements for application forms and replacement coverage.
89.785. Filing requirements for advertising.
89.786. Standards for marketing.
89.787. Appropriateness of recommended purchase and excessive insurance.

Authority

The provisions of this Subchapter K issued under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412), unless otherwise noted.

Source

The provisions of this Subchapter K adopted September 29, 1989, effective upon publication in the *Pennsylvania Bulletin*, 19 Pa.B. 4214, and does not supersede any of the sections of the Medicare Supplement Insurance Minimum Standards Regulation, published at 19 Pa.B. 3945 (September 16, 1989), unless otherwise noted.

§§ 89.751—89.757. [Reserved].

Source

The provisions of these §§ 89.751—89-757 adopted September 29, 1989, effective upon publication in the *Pennsylvania Bulletin*, 19 Pa.B. 4214, and does not supersede any of the sections of the Medicare Supplement Insurance Minimum Standards Regulation, published at 19 Pa.B. 3945 (September 16, 1989); reserved November 30, 1990, effective December 1, 1990, 20 Pa.B. 5928. Immediately preceding text appears at serial pages (143017) to (143021).

§§ 89.761—89.769. [Reserved].

Source

The provisions of these §§ 89.761—89-769 adopted November 30, 1990, effective December 1, 1990, 20 Pa.B. 5928; reserved July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841. Immediately preceding text appears at serial pages (154991) to (154998).

§ 89.770. Purpose.

This subchapter provides for the following:

(1) The reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies.

(2) The facilitation of public understanding and comparison of the policies.

(3) The elimination of provisions contained in the policies which may be misleading or confusing in connection with the purchase of the policies or with the settlement of claims.

(4) Full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

Source

The provisions of this § 89.770 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841.

§ 89.771. Applicability and scope.

(a) Except as otherwise specifically provided in §§ 89.775, 89.779, 89.780, 89.783 and 89.788, this subchapter applies to:

(1) Medicare supplement policies delivered or issued for delivery in this Commonwealth on or after July 30, 1992.

(2) Certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this Commonwealth.

(b) This subchapter does not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employes or former employes, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

Source

The provisions of this § 89.771 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841; amended May 10, 1996, effective May 11, 1996, 26 Pa.B. 2196. Immediately preceding text appears at serial page (171528).

Cross References

This section cited in 31 Pa. Code § 89.783 (relating to required disclosure provisions).

§ 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—

(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 Advantage organization 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. No. 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.

Employee welfare benefit plan—A plan, fund or program of employee 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 Advantage plan—A plan of coverage for health benefits under Medicare Part C as defined in section 1859(b)(1) of the Social Security Act (42 U.S.C.A. § 1395w-28(b)(1)) and includes:

(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 plans.

(ii) Medicare medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account.

(iii) Medicare Advantage private fee-for-service plans.

Medicare supplement policy—

(i) 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. § 1395mm) or a policy issued under a demonstration project specified in section 1882(g)(1), of the Social Security Act (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.

(ii) The term does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug Plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits under an agreement under section 1833(a)(1)(A) of the Social Security Act (42 U.S.C.A. § 1395l(a)(1)(A)).

Policy form—The form on which the policy is delivered or issued for delivery by the issuer.

Prestandardized Medicare supplement benefit plan—A group or individual policy of Medicare supplement insurance issued prior to July 30, 1992.

Producer—An insurance producer as defined by the Article VI-A of The Insurance Department Act of 1921 (40 P. S. §§ 310.1—310.99a), known as the Producer Licensing Modernization Act.

Authority

The provisions of this § 89.772 amended under the Omnibus Budget Reconciliation Act (OBRA 90) of November 15, 1990, P. L. 101—508; sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P.S. §§ 66, 186, 411 and 412); and sections 354 and 616 of The Insurance Company Law of 1921 (40 P.S. §§ 477b and 751); under the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. No. 100-275, 122 Stat. 2494); the Genetic Information Nondiscrimination Act of 2008 (Pub. L. No. 110-233, 122 Stat. 881); and 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).

Source

The provisions of this § 89.772 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841; amended September 2, 1994, effective November 2, 1994, 24 Pa.B. 4467; amended May 10, 1996, effective May 11, 1996, 26 Pa.B. 2196; amended January 8, 1999, effective January 9, 1999, 29 Pa.B. 172; amended December 29, 2000, effective December 30, 2000, 30 Pa.B. 6886; amended May 6, 2005, effective May 7, 2005, 35 Pa.B. 2729; amended April 24, 2009, effective April 25, 2009, 39 Pa.B. 2086; amended September 7, 2018, effective September 8, 2018, 48 Pa.B. 5601. Immediately preceding text appears at serial pages (342811) to (342813).

Cross References

This section cited in 31 Pa. Code § 89.791 (relating to prohibition against use of genetic information and requests for genetic testing).

§ 89.773. Policy definitions and terms.

A policy or certificate may not be advertised, solicited or issued for delivery in this Commonwealth as a Medicare supplement policy or certificate, unless the policy or certificate contains definitions or terms which conform to the requirements of this section.

(1) The terms ''accident,'' ''accidental injury'' or ''accidental means'' shall be defined to employ ''result'' language and may not include words which establish an accidental means test or use words, such as ''external, violent, visible wounds'' or similar words of description or characterization.

(i) The definition may not be more restrictive than the following: ''Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force.''

(ii) The definition may provide that injuries may not include injuries for which benefits are provided or available under workers' compensation, employer's liability or similar law or motor vehicle no-fault plan, unless prohibited by law.

(2) The terms ''benefit period'' or ''Medicare benefit period'' may not be defined more restrictively than as defined in the Medicare Program.

(3) The terms ''convalescent nursing home,'' ''extended care facility'' or ''skilled nursing facility'' may not be defined more restrictively than as defined in the Medicare Program.

(4) The term ''health care expenses'' for purposes of § 89.780 (relating to loss ratio standards and refund or credit of premium), shall be defined to mean expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

(5) The term ''hospital'' may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare Program.

(6) The term ''Medicare'' shall be defined in the policy and certificate. Medicare may be substantially defined as ''The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended,'' or ''Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof,'' or words of similar import.

(7) The term ''Medicare eligible expenses'' shall be defined to mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

(8) The term ''physician'' may not be defined more restrictively than as defined in the Medicare Program.

(9) The term ''sickness'' may not be defined to be more restrictive than the following: ''Sickness means illness or disease of an insured person which is diagnosed or treated after the effective date of insurance and while the insurance is in force.'' The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

Source

The provisions of this § 89.773 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841; amended May 6, 2005, effective May 7, 2005, 35 Pa.B. 2729. Immediately preceding text appears at serial pages (272513) to (272514).

Cross References

This section cited in 31 Pa. Code § 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); and 31 Pa. Code § 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).

§ 89.774. Exclusions and limitations.

(a) Except for permitted preexisting condition clauses as described in §§ 89.775(1)(i), 89.776(1)(i) and 89.776a(1)(i) (relating to minimum benefit standards for policies or certificates issued for delivery prior to July 30, 1992; benefit standards for policies or certificates issued or delivered on or after July 30, 1992 and prior to June 1, 2010; and benefit standards for policies or certificates issued or delivered on or after June 1, 2010), 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.

(d) The following applies to issuance and renewal limitations of Medicare supplement policies:

(1) Subject to §§ 89.775(1)(iv), (v) and (vii) and 89.776 (1)(iv) and (v) (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, and prior to June 1, 2010), a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

(2) A Medicare supplement policy with benefits for outpatient prescription drugs may not be issued after December 31, 2005.

(3) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless the following conditions apply:

(i) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan.

(ii) Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

Authority

The provision of this § 89.774 amended under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412), the Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No 100-275, 122 Stat. 2494 and the Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, 122 Stat. 881.

Source

The provisions of this § 89.774 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841; amended January 8, 1999, effective January 9, 1999, 29 Pa.B. 172; amended May 6, 2005, effective May 7, 2005, 35 Pa.B. 2729; amended April 24, 2009, effective April 25, 2009, 39 Pa.B. 2086. Immediately preceding text appears at serial pages (311178) to (311179).

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

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

(1) *General standards*. The following standards apply to Medicare supplement policies and certificates and are in addition to the other requirements of this subchapter:

(i) *Exclusion/limitation of benefits*. A Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

(ii) *Indemnification of sickness and accidents*. A Medicare supplement policy or certificate may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(iii) *Cost sharing amounts under Medicare*. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with changes in the applicable Medicare deductible amount, copayment, and coinsurance percentage factors. Premiums may be modified to correspond with these changes.

(iv) *Termination of coverage*. A noncancellable, guaranteed renewable or noncancellable and guaranteed renewable Medicare supplement policy may not:

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

(B) Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

(v) *Restrictions on termination of policies and certificates*.

(A) Except as authorized by the Commissioner, an issuer may neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(B) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in clause (D), the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:

(I) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy.

(II) An individual Medicare supplement policy which provides only benefits that are required to meet the minimum standards as defined in § 89.776a(2) (relating to benefit standards for policies or certificates issued or delivered on or after June 1, 2010).

(C) If membership in a group is terminated, the issuer shall do one of the following:

(I) Offer the certificateholder conversion opportunities that are described in clause (B).

(II) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(D) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy will not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(vi) Termination of a Medicare supplement policy or certificate shall be without prejudice to a continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(vii) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Pre-

scription Drug, Improvement, and Modernization Act of 2003, the act of December 8, 2003 (Pub. L. No. 108-173, 117 Stat. 2066), the modified policy shall be deemed to satisfy the guaranteed renewal requirement of this subsection.

(viii) If a hospital plan corporation or a professional health services plan corporation issues a subscriber contract which does not include the required benefits, the contract shall be issued in conjunction with another contract, including at least the remainder of the benefits in this subchapter, to qualify as Medicare supplement insurance. In the alternative, two or more corporations may act jointly and issue a single contract which contains the required benefits.

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

(i) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

(ii) Coverage for all or none of the Medicare Part A inpatient hospital deductible amount. If the insurer desires, in consideration of a reduced premium, to offer a contract without coverage for the initial deductible under Part A, it may do so only if the insured is given the option of purchasing the contract from that insurer with coverage for all of the Part A deductible.

(iii) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during the use of Medicare's lifetime hospital inpatient reserve days.

(iv) Upon exhaustion of Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days.

(v) Coverage under Medicare Part A for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under Federal regulations, unless replaced in accordance with Federal regulations or already paid for under Part B.

(vi) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible.

(vii) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under Federal regulations, unless replaced in accordance with Federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

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(viii) If a hospital plan corporation or a professional health service plan corporation issues a subscriber contract which does not include the required benefits, the contract shall be issued in conjunction with another contract, including at least the remainder of the benefits in this subchapter, to qualify as Medicare supplement insurance. In the alternative, two or more corporations may act jointly and issue a single contract which contains the required benefits.

Authority

The provisions of this § 89.775 amended under the Omnibus Budget Reconciliation Act (OBRA 90) of November 15, 1990, P. L. 101—508; sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and sections 356 and 616 of The Insurance Company Law of 1921 (40 P. S. §§ 477b and 751); amended under the Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 100-275, 122 Stat. 2494 and the Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, 122 Stat. 881.

Source

The provisions of this § 89.775 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841; amended September 2, 1994, effective November 2, 1994, 24 Pa.B. 4467; amended May 10, 1996, effective May 11, 1996, 26 Pa.B. 2196; amended November 22, 2002, effective November 23, 2002, apply retroactively to October 24, 2002, 32 Pa.B. 5743; amended May 6, 2005, effective May 7, 2005, 35 Pa.B. 2729; amended April 24, 2009, effective April 25, 2009, 39 Pa.B. 2086. Immediately preceding text appears at serial pages (311179) to (311182).

Cross References

This section cited in 31 Pa. Code § 89.771 (relating to applicability and scope); and 31 Pa. Code § 89.774 (relating to exclusions and limitations).

§ 89.776. Benefits standards for policies or certificates issued or delivered on or after July 30, 1992, and prior to June 1, 2010.

The following standards apply to 1990 Standardized Medicare supplement benefit plans. A policy or certificate may not be advertised, solicited, delivered or issued for delivery in this Commonwealth as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(1) *General standards*. The following standards apply to Medicare supplement policies and certificates and are in addition to other requirements of this subchapter:

(i) *Exclusions and limitations*. A Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

(ii) *Indemnification of sickness and accidents*. A Medicare supplement policy or certificate may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(iii) *Cost sharing amounts under Medicare*. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with changes in the applicable Medicare deductible, copayment or coinsurance percentage factors. Premiums may be modified to correspond with these changes.

(iv) *Termination of coverage*. A Medicare supplement policy or certificate may not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(v) *Cancellation or nonrenewal of policy*. Each Medicare supplement policy shall be guaranteed renewable.

(A) The issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual.

(B) The issuer may not cancel or nonrenew the policy for a reason other than nonpayment of premium or material misrepresentation.

(C) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under clause (E), the issuer shall offer certificateholders an individual Medicare supplement policy which, at the option of the certificateholder, does one of the following:

(I) Provides for continuation of the benefits contained in the group policy.

(II) Provides for benefits that otherwise meet the requirements of this section.

(D) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall do one of the following:

(I) Offer the certificateholder the conversion opportunity described in clause (C).

(II) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(E) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to persons covered under the old group policy on its date of termination. Coverage under the new policy may not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(F) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the act of

December 8, 2003 (Pub. L. No. 108-173, 117 Stat. 2066), the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

(vi) *Extension of benefits*. Termination of a Medicare supplement policy or certificate shall be without prejudice to a continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(vii) *Suspension by policyholder*.

(A) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed 24 months) in which the policyholder or certificateholder has applied for and is determined to be entitled to Medical Assistance under Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396—1396u), but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to this assistance.

(B) If a suspension occurs and if the policyholder or certificateholder loses entitlement to Medical Assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of the entitlement) as of the termination of the entitlement if the policyholder or certificateholder provides notice of loss of the entitlement within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of the entitlement.

(C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act (42 U.S.C.A. § 426(b)) and is covered under a group health plan (as defined in section 1862 (b)(1)(A)(v) of the Social Security Act (42 U.S.C.A. § 1395y(b)(1)(A)(v)). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

(D) Reinstitution of these coverages as described in clauses (B) and (C):

(I) May not provide for a waiting period with respect to treatment of preexisting conditions.

(II) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of the suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension.

(III) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder if the coverage had not been suspended.

(viii) If an issuer makes a written offer to a Medicare supplement policyholder or certificateholder of one or more of its plans to exchange, during a specified period, a 1990 Standardized Medicare supplement benefit plan with a 2010 Standardized Medicare supplement benefit plan, the offer and subsequent exchange shall comply with the following requirements:

(A) The issuer need not provide justification to the Commissioner if the insured replaces the 1990 Standardized Medicare supplement benefit plan policy or certificate with an issue age rated 2010 Standardized Medicare supplement benefit plan policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of the offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by the issuer must be filed with and approved by the Commissioner in accordance with the filing requirements and procedures required by the Commissioner.

(B) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(C) The issuer may not apply new preexisting condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized Medicare supplement benefit plan policy or certificate of the insured, but may apply pre-existing condition limitations of no more than 6 months to any added benefits contained in the new 2010 Standardized Medicare supplement benefit plan policy or certificate not contained in the exchanged policy.

(D) The new policy or certificate shall be offered to all policyholders or certificateholders within a given plan, except if the offer or issue would be in violation of State or Federal law.

(2) *Standards for basic (core) benefits common to benefit Plans A—J.* Every issuer shall make available a policy or certificate, including only the following basic core package of benefits to each prospective insured. An issuer

shall also offer a policy or certificate to prospective insureds meeting the Plan B benefit plan. An issuer may make available to prospective insureds Medicare Supplement Insurance Benefit Plans C, D, E, F, G, H, I and J as listed in § 89.777(e) (relating to standard Medicare supplement benefit plans). The core packages are as follows:

(i) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

(ii) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(iii) Upon 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 (PPS) 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.

(iv) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations.

(v) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(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 or State law, including 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.

(vi) *Basic outpatient prescription drug benefit*. Coverage for 50% of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(vii) *Extended outpatient prescription drug benefit*. Coverage for 50% of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(viii) *Medically necessary emergency care in a foreign country*. Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, ''emergency care'' means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(ix) *Preventive medical care benefit*. Reimbursement shall be for the actual charges up to 100% of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit may not include payment for a procedure covered by Medicare. Coverage for the preventive health services not covered by Medicare is as follows:

(A) An annual clinical preventive medical history and physical examination that may include tests and services described in clause (B) and patient education to address preventive health care measures.

(B) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

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(x) *At-home recovery benefit*. Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

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

(I) *Activities of daily living*—The term includes bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered and changing bandages or other dressings.

(II) *Care provider*—A qualified or licensed home health aid or homemaker, personal care aid or nurse provided through a licensed home health care agency or referred by a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(III) *Home*—A place used by the insured as a place of residence, if the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility may not be considered the insured's place of residence.

(IV) *At-home recovery visit*—The period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except that each consecutive 4 hours in a 24-hour period of services provided by a care provider is one visit.

(B) Coverage requirements and limitations are as follows:

(I) At-home recovery services provided shall be primarily services which assist in activities of daily living.

(II) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(III) Coverage is limited to:

(-a-) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits may not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

(-b-) The actual charges for each visit up to a maximum reimbursement of $40 per visit.

(-c-) One thousand six hundred dollars per calendar year.

(-d-) Seven visits in 1 week.

(-e-) Care furnished on a visiting basis in the insured's home.

(-f-) Services provided by a care provider as defined in this section.

(-g-) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(-h-) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than 8 weeks after the service date of the last Medicare approved home health care visit.

(C) Coverage is excluded for:

(I) Home care visits paid for by Medicare or other government programs.

(II) Care provided by family members, unpaid volunteers or providers who are not care providers.

(4) *Standards for Plans K and L.*

(i) Standardized Medicare supplement benefit Plan K shall consist of the following:

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

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

(C) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of the 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.

(D) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in clause (J).

(E) Skilled nursing facility care: Coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in clause (J).

(F) Hospice care: Coverage for 50% of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in clause (J).

(G) Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) unless replaced in accordance with Federal regulations until the out-of-pocket limitation is met as described in clause (J).

(H) Except for coverage provided in clause (I), coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the poli-

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cyholder pays the Part B deductible until the out-of-pocket limitation is met as described in clause (J).

(I) Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible.

(J) Coverage of 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the HHS Secretary.

(ii) Standardized Medicare supplement benefit Plan L shall consist of the following:

(A) The benefits described in subparagraph (i)(A), (B), (C) and (I).

(B) The benefits described in subparagraph (i)(D), (E), (F), (G) and (H), but substituting 75% for 50%.

(C) The benefit described in subparagraph (i)(J) but substituting $2,000 for $4,000.

Authority

The provisions of this § 89.776 amended under the Omnibus Budget Reconciliation Act (OBRA 90) of November 15, 1990, P. L. 101—508; sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and sections 356 and 616 of The Insurance Company Law of 1921 (40 P. S. §§ 477b and 751); amended under the Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 100-275, 122 Stat. 2494 and the Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, 122 Stat. 881.

Source

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Cross References

This section cited in 31 Pa. Code § 89.774 (relating to exclusions and limitations); and 31 Pa. Code § 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).

§ 89.776a. Benefit standards for policies or certificates issued or delivered on or after June 1, 2010.

The following standards apply to 2010 Standardized Medicare supplement benefit plans. An issuer may not offer any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. A policy or certificate may not be

advertised, solicited, delivered or issued for delivery in this Commonwealth as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(1) *General standards*. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(i) *Exclusions or limitations*. A Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than 6 months after the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

(ii) *Indemnification of sickness and accidents*. A Medicare supplement policy or certificate may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(iii) *Cost sharing amounts under Medicare*. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment or coinsurance amounts. Premiums may be modified to correspond with these changes.

(iv) *Termination of coverage*. A Medicare supplement policy or certificate may not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(v) *Cancellation or nonrenewal of policy*. Each Medicare supplement policy is guaranteed renewable.

(A) The issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual.

(B) The issuer may not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(C) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under clause (E), the issuer shall offer certificateholders an individual Medicare supplement policy which, at the option of the certificateholder, does one of the following:

(I) Provides for continuation of the benefits contained in the group policy.

(II) Provides for benefits that otherwise meet the requirements of this section.

(D) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall do one of the following:

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(I) Offer the certificate holder the conversion opportunity described in clause (C).

(II) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(E) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy may not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(vi) *Extension of benefits*. Termination of a Medicare supplement policy or certificate is without prejudice to any continuous loss which began while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(vii) *Suspension by policyholder*.

(A) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed 24 months) in which the policyholder or certificate holder has applied for and is determined to be entitled to Medical Assistance under Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396—1396u), but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to this assistance.

(B) If a suspension occurs and if the policyholder or certificateholder loses entitlement to Medical Assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of the termination of entitlement.

(C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act (42 U.S.C.A. § 426(b)) and is covered under a group health plan (as defined in section 1862 (b)(1)(A)(v) of the Social Security Act (42 U.S.C.A. § 1395y(b)(1)(A)(v)). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage

within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

(D) Reinstitution of coverages as described in clauses (B) and (C):

(I) May not provide for any waiting period with respect to treatment of preexisting conditions.

(II) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension.

(III) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder if the coverage had not been suspended.

(2) *Standards for basic (core) benefits common to benefit Plans A—D, F, F with high deductible, G, M and N*. Every issuer shall make available a policy or certificate, including only the following basic (core) package of benefits to each prospective insured. An issuer shall also offer a policy or certificate to prospective insureds meeting the Plan B benefit plan. An issuer may also make available to prospective insureds any Medicare Supplement Insurance Benefit Plan in addition to the basic core package, but not instead of it. The core packages are as follows:

(i) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from day 61 through day 90 in any Medicare benefit period.

(ii) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(iii) Upon 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 (PPS) 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.

(iv) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells as defined under Federal regulations, unless replaced in accordance with Federal regulations.

(v) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(vi) Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

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(3) *Standards for additional benefits*. The following additional benefits shall be included in Medicare supplement benefit Plans B—D, F, F with High Deductible, G, M and N as provided by § 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).

(i) *Medicare Part A deductible*. Coverage for 100% of the Medicare Part A inpatient hospital deductible amount per benefit period.

(ii) *Medicare Part A deductible*. Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period.

(iii) *Skilled nursing facility care*. Coverage for the actual billed charges up to the coinsurance amount from day 21 through day 100 in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

(iv) *Medicare Part B deductible*. Coverage for 100% of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(v) *Medicare Part B excess charges*. Coverage for 100% of the difference between the Medicare Part B charges billed, not to exceed a charge limitation established by the Medicare program or state law including the Health Care Practitioner Medicare Fee Control Act (35 P. S. §§ 449.31—449.36), and the Medicare-approved Part B charge.

(vi) *Medically necessary emergency care in a foreign country*. Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250 and a lifetime maximum benefit of $50,000. For purposes of this benefit, ''emergency care'' means care needed immediately because of an injury or an illness of sudden and unexpected onset.

Authority

The provision of this § 89.776a issued under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412), the Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 100-275, 122 Stat. 2494 and the Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, 122 Stat. 881.

Source

The provisions of this § 89.776a adopted April 24, 2009, effective April 25, 2009, 39 Pa.B. 2086.

Cross References

This section cited in 31 Pa. Code § 89.774 (relating to exclusions and limitations); 31 Pa. Code § 89.775 (relating to minimum benefit standards for policies or certificates issued for delivery prior to July 30, 1992); and 31 Pa. Code § 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).

§ 89.777. 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.

(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, and prior to June 1, 2010). 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 not be offered for sale in this Commonwealth except as may be permitted in subsection (f) and § 89.777a (relating to Medicare select policies and certificates).

(c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit Plans A—L 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) or (4) 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

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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). The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(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). The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(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). The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(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. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(13) Standardized Medicare Supplement benefit Plan K shall consist of only those benefits described in § 89.776 (4)(i).

(14) Standardized Medicare Supplement benefit Plan L shall consist of only those benefits described in § 89.776 (4)(ii).

(f) New or innovative benefits must conform to this subsection. An issuer may, with the prior approval of the Commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit may not include an outpatient prescription drug program.

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Authority

The provisions of this § 89.777 amended under the Omnibus Budget Reconciliation Act (OBRA 90) of November 15, 1990, P. L. 101—508; sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and sections 356 and 616 of The Insurance Company Law of 1921 (40 P. S. §§ 477b and 751); amended under the Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 100-275, 122 Stat. 2494 and the Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, 122 Stat. 881.

Source

The provisions of this § 89.777 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841; corrected July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841; amended September 2, 1994, effective November 2, 1994, 24 Pa.B. 4467; amended January 8, 1998, effective January 9, 1999, 29 Pa.B. 172; amended May 6, 2005, effective May 7, 2005, 35 Pa.B. 2729; amended April 24, 2009, effective April 25, 2009, 39 Pa.B. 2086. Immediately preceding text appears at serial pages (311190) to (311193).

Cross References

This section cited in 31 Pa. Code § 89.776 (relating to benefits standards for policies or certificates issued or delivered on or after July 30, 1992, and prior to June 1, 2010); and 31 Pa. Code § 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).

§ 89.777a. Medicare select policies and certificates.

(a) This section applies to Medicare Select policies and certificates, as defined in this section.

(b) A policy or certificate may not be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(c) For the purposes of this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:

Complaint—Dissatisfaction expressed orally or in writing by an individual insured under a Medicare Select policy or certificate concerning a Medicare Select issuer or its network providers.

Grievance—Dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate concerning the administration, claims practices or provision of services with a Medicare Select issuer or its network providers.

Medicare Select issuer—An issuer offering, or seeking to offer, a Medicare Select policy or certificate.

Medicare Select policy or *Medicare Select certificate*—A Medicare supplement policy or certificate, respectively, that contains restricted network provisions.

Network provider—A provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

Restricted network provision—A provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

Service area—The geographic area approved by the Commissioner within which an issuer is authorized to offer a Medicare Select policy.

(d) The Commissioner may authorize an issuer to offer a Medicare Select policy or certificate, under this section, and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 (42 U.S.C.A. § 1395b-2) if the Commissioner finds that the issuer has satisfied the requirements of this section.

(e) A Medicare Select issuer may not issue a Medicare Select policy or certificate in this State until its plan of operation has been approved by the Commissioner.

(f) A Medicare Select issuer shall file a proposed plan of operation with the Commissioner in a format prescribed by the Commissioner. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(i) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect the usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(ii) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, to either:

(A) Deliver adequately all services that are subject to a restricted network provision.

(B) Make appropriate referrals.

(iii) There are written agreements with network providers describing both parties' specific responsibilities.

(iv) Emergency care is available 24 hours per day and 7 days per week.

(v) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This subparagraph does not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) A statement or map providing a clear description of the service area.

(3) A description of the grievance procedure to be utilized.

(4) A description of the complaint procedure to be utilized.

(5) A description of the quality assurance program, including the following:

(i) The formal organizational structure.

(ii) The written criteria for selection, retention and removal of network providers.

(iii) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(6) A list and description, by specialty, of the network providers.

(7) Copies of the written information proposed to be used by the issuer to comply with subsection (j).

(8) Other information pertinent to the plan of operation requested by the Commissioner.

(g) A Medicare Select issuer shall file:

(1) Proposed changes to the plan of operation, except for changes to the list of network providers, with the Commissioner prior to implementing the changes. Changes shall be considered approved by the Commissioner after 30 days unless specifically disapproved.

(2) An updated list of network providers with the Commissioner at least quarterly, if changes occur.

(h) A Medicare Select policy or certificate may not restrict payment for covered services provided by nonnetwork providers if the following apply:

(1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition.

(2) It is not reasonable to obtain services through a network provider.

(i) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

(j) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(i) Medicare supplement policies or certificates offered by the issuer.

(ii) Other Medicare Select policies or certificates.

(2) A description, including the address, phone number and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

(3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in Plans K and L.

(4) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(5) A description of limitations on referrals to restricted network providers and to other providers.

(6) A description of the policyholder's rights to purchase another Medicare supplement policy or certificate otherwise offered by the issuer.

(7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.

(k) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided under subsection (j) and that the applicant understands the restrictions of the Medicare Select policy or certificate.

(l) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The complaint and grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a complaint or grievance may be registered with the issuer.

(3) Complaints and grievances shall be considered within 45 days. If a benefit determination by Medicare is necessary, the 45-day review period may not begin until after the Medicare determination has been made. The complaint or grievance shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(4) If a complaint or grievance is found to be valid, corrective action shall be taken within 45 days.

(5) The concerned parties shall be notified about the results of a complaint or grievance within 45 days of the decision.

(6) The issuer shall report by March 31 to the Commissioner regarding its grievance procedure. The report shall be in a format prescribed by the Commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of the grievances.

(m) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(n) For purposes of this section the following apply:

(1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for 6 months.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it

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contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a ''significant benefit'' means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

(o) Medicare Select policies and certificates shall provide for continuation of coverage in the event the United States Department of Health and Human Services Secretary determines that Medicare Select policies and certificates issued under this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a ''significant benefit'' means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

(p) A Medicare Select issuer shall comply with reasonable requests for data made by State or Federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

Source

The provisions of this § 89.777a adopted May 5, 2000, effective May 6, 2000, 30 Pa.B. 2229; amended May 6, 2005, effective May 7, 2005, 35 Pa.B. 2729. Immediately preceding text appears at serial pages (266433) to (266437).

Cross References

This section cited in 31 Pa. Code § 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); and 31 Pa. Code § 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).

§ 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.

(iv) *Medicare Part A deductible*. Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (x).

(v) *Skilled nursing facility care*. Coverage for 50% of the coinsurance amount for each day used from day 21 through the day 100 in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph (x).

(vi) *Hospice care*. Coverage for 50% of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (x).

(vii) *Blood*. Coverage for 50% under Medicare Part A or B, of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under Federal regulations, unless replaced in accordance with Federal regulations until the out-of-pocket limitation is met as described in subparagraph (x).

(viii) *Part B cost sharing*. Except for coverage provided in subparagraph (ix), coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in clause (J).

(ix) *Part B preventive services*. Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible.

(x) *Cost sharing after out-of-pocket limits*. Coverage of 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the HHS Secretary.

(9) Standardized Medicare supplement Plan L shall consist of the following:

(i) The benefits described in paragraph (8)(i), (ii), (iii) and (ix).

(ii) The benefit described in paragraph (8)(iv), (v), (vi), (vii) and (viii), but substituting 75% for 50%.

(iii) The benefit described in paragraph (8)(x), but substituting $2,000 for $4,000.

(10) Standardized Medicare supplement Plan M shall include only the following: the basic (core) benefit as defined in § 89.776a(2), plus 50% of the Medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in a foreign country as defined in § 89.776a(3)(ii), (iii) and (vi).

(11) Standardized Medicare supplement Plan N 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 a foreign country as defined in § 89.776a(3)(i), (iii) and (vi), with co-payments in the following amounts:

(i) The lesser of $20 or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit, including visits to medical specialists.

(ii) The lesser of $50 or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, except that the co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(g) *New or innovative benefits*. New or innovative benefits must conform to this subsection. An issuer may, with the prior approval of the Commissioner, offer policies or certificates with new or innovative benefits in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include only benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. New or innovative benefits may not include an outpatient prescription drug benefit. New or innovative benefits may not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

Authority

The provision of this § 89.777b issued under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P.S. §§ 66, 186, 411 and 412), the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. No. 100-275, 122 Stat. 2494); the Genetic Information Nondiscrimination Act of 2008 (Pub. L. No. 110-233, 122 Stat. 881); amended under 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); sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P.S. §§ 66, 186, 411 and 412).

Source

The provisions of this § 89.777b adopted April 24, 2009, effective April 25, 2009, 39 Pa.B. 2086; amended September 7, 2018, effective September 8, 2018, 48 Pa.B. 5601. Immediately preceding text appears at serial pages (346799) to (346800) and (342841) to (342843).

Cross References

This section cited in 31 Pa. Code § 89.776a (relating to benefit standards for policies or certificates issued or delivered on or after June 1, 2010); 31 Pa. Code § 89.777c (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; and 31 Pa. Code § 89.783 (relating to required disclosure provisions).

§ 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).

Authority

The provisions of this § 89.777c issued under 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).

Source

The provisions of this § 89.777c adopted September 7, 2018, effective September 8, 2018, 48 Pa.B. 5601.

Cross References

This section cited in 31 Pa. Code § 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).

§ 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.

Authority

The provisions of this § 89.778 amended under the Omnibus Budget Reconciliation Act (OBRA 90) of November 15, 1990, P. L. 101—508; sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P.S. §§ 66, 186, 411 and 412); sections 356 and 616 of The Insurance Company Law of 1921 (40 P.S. §§ 477b and 751); 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).

Source

The provisions of this § 89.778 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841; amended September 2, 1994, effective November 2, 1994, 24 Pa.B. 4467; amended May 10, 1996, effective May 11, 1996, 26 Pa.B. 2196; amended January 8, 1999, effective January 9, 1999, 29 Pa.B. 172; amended May 6, 2005, effective May 7, 2005, 35 Pa.B. 2729; amended September 7, 2018, effective September 8, 2018, 48 Pa.B. 5601. Immediately preceding text appears at serial pages (342843) to (342844).

§ 89.779. Standards for claims payment.

(a) An issuer shall comply with section 1882(c)(3) of the Social Security Act (42 U.S.C.A. § 1395ss(c)(3) (as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, the act of December 22, 1987 (Pub.L. No. 100, 101 Stat. 1330) by:

(1) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of another claim form otherwise required and making a payment determination on the basis of the information contained in that notice.

(2) Notifying the participating physician or supplier and the beneficiary of the payment determination.

(3) Paying the participating physician or supplier directly.

(4) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent.

(5) Paying user fees for claim notices that are transmitted electronically or otherwise.

(6) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

(b) Compliance with the requirements in subsection (a) shall be certified on the Medicare supplement insurance experience reporting form.

Source

The provisions of this § 89.779 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841.

Cross References

This section cited in 31 Pa. Code § 89.771 (relating to applicability and scope).

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

(a) *Loss ratio standards.*

(1) A Medicare Supplement policy form or certificate form may not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to return to policyholders and certificateholders in the form of aggregate benefits, a percentage of the aggregate amount of premiums earned as listed in this paragraph. The amount returned to policyholders and certificateholders shall be calculated on the basis of incurred claims experience or incurred health care expenses when coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and on earned premiums for the period. The calculation shall be made in accordance with accepted actuarial principles and practices. This does not include anticipated refunds or credits provided under the policy form or certificate form. The amount returned as benefits shall be equal to:

(i) At least 75% of the aggregate amount of premiums earned in the case of group policies.

(ii) At least 65% of the aggregate amount of premiums earned in the case of individual policies.

(2) Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(i) Home office and overhead costs.

(ii) Advertising costs.

(iii) Commissions and other acquisition costs.

(iv) Taxes.

(v) Capital costs.

(vi) Administrative costs.

(vii) Claims processing costs.

(3) Filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(4) For policies issued prior to July 30, 1992, expected claims in relation to premiums shall meet the following:

(i) The originally filed anticipated loss ratio when combined with the actual experience since inception.

(ii) The appropriate loss ratio requirement from paragraph (1) when combined with actual experience beginning with May 11, 1996, to date.

(iii) The appropriate loss ratio requirement from paragraph (1) over the entire future period for which the rates are computed to provide coverage.

(b) *Refund or credit calculation.*

(1) An issuer shall collect data for each standard Medicare supplement benefit plan and file the data with the Commissioner on or by May 31 of each year using an applicable Refund Calculation Form, as prescribed by the Department.

(2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a Statewide basis for each type in a standard Medicare supplement

benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) For the purposes of this section, for policies or certificates issued prior to July 30, 1992, the issuer shall make the refund or credit calculation separately for all individual policies combined and all other group policies combined for experience after May 11, 1996. The first report is due by May 31, 1998.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. This refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but it may not be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(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.

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

(2) Appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. These riders, endorsements or policy

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forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(d) *Public hearings*. The Commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before, on or after July 30, 1992, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the Commissioner.

Authority

The provisions of this § 89.780 amended under the Omnibus Budget Reconciliation Act (OBRA 90) of November 15, 1990, P. L. 101—508; sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and sections 356 and 616 of The Insurance Company Law of 1921 (40 P. S. §§ 477b and 751).

Source

The provisions of this § 89.780 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841; amended September 2, 1994, effective November 2, 1994, 24 Pa.B. 4467; amended May 10, 1996, effective May 11, 1996, 26 Pa.B. 2196; amended January 8, 1999, effective January 9, 1999, 29 Pa.B. 172; amended May 6, 2005, effective May 7, 2005, 35 Pa.B. 2729. Immediately preceding text appears at serial pages (266439) and (252235) to (252237).

Cross References

This section cited in 31 Pa. Code § 89.771 (relating to applicability and scope); 31 Pa. Code § 87.773 (relating to policy definitions and terms); and 31 Pa. Code § 89.781 (relating to filing and approval of policies and certificates and premium rates).

§ 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) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the act of December 8, 2003 (Pub. L. No. 108-173, 117 Stat. 2066), only with the commissioner in the state in which the policy or certificate was issued.

(c) *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.

(d) *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 producer 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.

(e) *Availability of policy form.*

(1) Except as provided in subsection (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.

(i) 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.

(ii) An issuer that discontinues the availability of a policy form or certificate form under subsection (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.

(f) *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).

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(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.

Authority

The provisions of this § 89.781 amended under the Omnibus Budget Reconciliation Act (OBRA 90) of November 15, 1990, P. L. 101—508; sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and sections 356 and 616 of The Insurance Company Law of 1921 (40 P. S. §§ 477b and 751).

Source

The provisions of this § 89.781 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841; amended September 2, 1994, effective November 2, 1994, 24 Pa.B. 4467; amended January 8, 1999, effective January 9, 1999, 29 Pa.B. 172; amended May 6, 2005, effective May 7, 2005, 35 Pa.B. 2729. Immediately preceding text appears at serial pages (252237) to (252238) and (272523).

§ 89.782. Permitted compensation arrangements.

(a) An issuer or other entity may provide a commission or other compensation to a producer or other representative for the sale of a Medicare supplement policy or certificate only if the 1st-year commission or other 1st- year compensation is no more than 200% of the commission or other compensation paid for selling or servicing the policy or certificate in the 2nd year or period.

(b) The commission or other compensation provided in subsequent (renewal) years shall be the same as that provided in the 2nd year or period and shall be provided for no fewer than 5 renewal years.

(c) An issuer or other entity may not provide compensation to its producers or its other representatives and a producer may not receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

(d) For purposes of this section, compensation includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate, including bonuses, gifts, prizes, awards and finders fees.

Source

The provisions of this § 89.782 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841; amended May 6, 2005, effective May 7, 2005, 35 Pa.B. 2729. Immediately preceding text appears at serial page (272523).

§ 89.783. Required disclosure provisions.

(a) *General rules*.

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of this provision shall be consistent with the type of contract issued. This provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, riders or endorsements added to a Medicare supplement policy after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall

require a signed acceptance by the insured. After the date of policy or certificate issue, a rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. When a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(3) Medicare supplement policies or certificates may not provide for the payment of benefits based on standards described as ''usual and customary,'' ''reasonable and customary'' or similar words.

(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.''

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied. The notice shall contain a company mailing address to which the policyholder or certificateholder should direct the return policy or certificate. Upon receipt of a request for a refund, the company shall promptly refund the total premium amount paid directly to the policyholder or certificateholder. When an insurer asks questions in the application concerning the medical history of an individual applying for ''coverage,'' a notice shall be given to the individual urging them to verify the accuracy and completeness of the medical history information on the application and warning them that erroneous or incomplete application data could jeopardize their claim.

(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* in the form developed jointly by the National Association of Insurance Commissioners and Centers for Medicare & Medicaid Services (CMS) 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.

(7) For the purposes of this section, ''form'' means the language, format, type size, type proportional spacing, bold character and line spacing.

(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 policyhold-

ers 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.

(2) The notice of benefit modifications and premium adjustments shall be in outline form and in clear and simple terms to facilitate comprehension.

(3) These notices may not contain or be accompanied by solicitation.

(4) Once the Department has approved the form, a ''Notice of Change'' may 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) *MMA notice requirements*. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the act of December 8, 2003 (Pub. L. No. 108-173, 117 Stat. 2066).

(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.

Authority

The provisions of this § 89.783 amended under the Omnibus Budget Reconciliation Act (OBRA 90) of November 15, 1990, P. L. 101—508; sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P.S. §§ 66, 186, 411 and 412); sections 356 and 616 of The Insurance Company Law of 1921 (40 P.S. §§ 477b and 751); under the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. No. 100-275, 122 Stat. 2949); and the Genetic Information Nondiscrimina-

tion Act of 2008 (Pub. L. No. 110-233, 122 Stat. 881); 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).

Source

The provisions of this § 89.783 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841; amended September 3, 1994, effective November 2, 1994, 24 Pa.B. 4467; amended May 10, 1996, effective May 11, 1996, 26 Pa.B. 2196; amended January 8, 1999, effective January 9, 1999, 29 Pa.B. 172; amended December 29, 2000, effective December 30, 2000, 30 Pa.B. 6886; corrected January 12, 2001, effective January 13, 2001, 31 Pa.B. 145; amended November 22, 2002, effective November 23, 2002, apply retroactively to October 24, 2002, 32 Pa.B. 5743; amended May 6, 2005, effective May 7, 2005, 35 Pa.B. 2729; amended April 24, 2009, effective April 25, 2009, 39 Pa.B. 2086; amended September 7, 2018, effective September 8, 2018, 48 Pa.B. 5601. Immediately preceding text appears at serial pages (342851) to (342856).

Cross References

This section cited in 31 Pa. Code § 89.771 (relating to applicability and scope).

§ 89.784. Requirements for application forms and replacement coverage.

Application forms shall include the following requirements and questions designed to elicit information as to whether, as of the date of application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer containing these questions and statements may be used. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

(1) *Statements.*

(i) You do not need more than one Medicare supplement policy.

(ii) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(iii) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(iv) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy or, if the Medicare supplement policy is no longer available, a substantially equivalent policy will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(v) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend

your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

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

(2) *Questions*. If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

Please mark Yes or NO below with an ''X''

To the best of your knowledge,

(i) Did you turn age 65 in the last 6 months?

YES _____ NO _____

(ii) Did you enroll in Medicare Part B in the last 6 months?

YES _____ NO _____

(iii) If yes, what is the effective date? _____

(iv) Are you covered for medical assistance through the state Medicaid program?

YES _____ NO _____

(A) NOTE TO APPLICANT: If you are participating in a ''Spend-Down Program'' and have not met your ''Share of Cost,'' please answer NO to this question.

(B) If yes,

(1) Will Medicaid pay your premiums for this Medicare supplement policy?

YES _____ NO _____

(2) Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B premium?

YES _____ NO _____

(v) If you had any from any Medicare plan other than the original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave ''END'' blank.

START _____ / _____ / _____ END _____ / _____ / _____

(vi) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

YES _____ NO _____

(vii) Was this your first time in this type of Medicare plan?

YES _____ NO _____

(viii) Did you drop a Medicare supplement policy to enrollment in the Medicare Plan?

YES _____ NO _____

(ix) Do you have another Medicare supplement policy in force?

YES _____ NO _____

(A) If so, with what company and what plan do you have (optional for Direct Mailers)?

_____

(B) If so, do you intend to replace your current Medicare supplement policy with this policy?

YES _____ NO _____

(x) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

YES _____ NO _____

(A) If so, with what company and what kind of policy?

_____

_____

_____

_____

(B) What are your dates of coverage under the policy (If you are still covered under the other policy, leave ''END'' blank.)?

START _____ / _____ / _____ END _____ / _____ / _____

(3) Producers shall list on the application form the following health insurance policies they have sold to the applicant:

(i) Policies sold which are still in force.

(ii) Policies sold in the past 5 years which are no longer in force.

(4) *Notice*.

(i) If a sale involves replacement of Medicare supplement coverage, an issuer, other than a direct response issuer, or its agent shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent shall be provided to the applicant and an additional signed copy shall be retained by the issuer, except where the coverage is sold without an agent. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(ii) The notice for an issuer shall be provided in substantially the following form in at least 12 point type.

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NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

(Insurance company's name and address)

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

According to (your application) (information you have furnished), you intend to terminate existing Medicare supplement or Medicare Advantage and replace it with a policy to be issued by (Company Name) Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, PRODUCER (OR OTHER REPRESENTATIVE):

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

_____ Additional benefits.

_____ No change in benefits, but lower premium.

_____ Fewer benefits and lower premiums.

_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment (optional only for Direct Mailers.)

_____

_____

_____ Other. (please specify)

_____

_____

_____

(Signature of producer or other representative)*

(Typed Name and Address of issuer, producer or other representative)

_____

(Applicant's Signature)

_____

(Date)

* Signature not required for direct response sales.

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(iii) *Additional statements*. The notice shall include the following statements, except that clauses (A) and (B), applicable to preexisting conditions, may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation:

(A) If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(B) State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(C) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

(D) Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Authority

The provision of this § 89.784 amended under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412), the Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 100-275, 122 Stat. 2494 and the Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, 122 Stat. 881.

Source

The provisions of this § 89.784 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841; amended May 10, 1996, effective May 11, 1996, 26 Pa.B. 2196; amended May 6, 2005, effective May 7, 2005, 35 Pa.B. 2729; amended April 24, 2009, effective April 25, 2009, 39 Pa.B. 2086. Immediately preceding text appears at serial pages (312205) to (312206) and (311213) to (311215).

§ 89.785. Filing requirements for advertising.

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this Commonwealth whether through written, radio or television medium to the Commissioner for review or approval by the Commissioner to the extent it may be required under State law.

Source

The provisions of this § 89.785 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841.

§ 89.786. Standards for marketing.

(a) An issuer, directly or through its producers, shall:

(1) Establish marketing procedures to assure that comparison of policies by its producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

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

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of this insurance.

(5) Establish auditable procedures for verifying compliance with this subsection.

(b) In addition to the practices prohibited by the Unfair Insurance Practices Act (40 P. S. §§ 1171.1—1171.15), the following acts and practices are prohibited:

(1) *Twisting*. Knowingly making any misleading representation or incomplete or fraudulent comparison of insurance policies or insurers for the purpose of inducing, or tending to induce, a person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert an insurance policy or to take out a policy of insurance with another insurer.

(2) *High pressure tactics*. Employing a method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) *Cold lead advertising*. Making use directly or indirectly of a method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by a producer or insurance company.

(c) The terms ''Medicare Supplement,'' ''Medigap,'' ''Medicare Wrap-Around'' and similar words may not be used unless the policy is issued in compliance with this subchapter.

Source

The provisions of this § 89.786 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841; amended May 6, 2005, effective May 7, 2005, 35 Pa.B. 2729. Immediately preceding text appears at serial pages (272563) to (272564).

§ 89.787. Appropriateness of recommended purchase and excessive insurance.

(a) In recommending the purchase or replacement of a Medicare supplement policy or certificate, a producer shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(b) A sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

(c) An issuer may not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

Source

The provisions of this § 89.787 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841; amended May 6, 2005, effective May 7, 2005, 35 Pa.B. 2729. Immediately preceding text appears at serial page (272564).

§ 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.

Source

The provisions of this § 89.788 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841; amended January 8, 1999, effective January 9, 1999, 29 Pa.B. 172. Immediately preceding text appears at serial page (214647).

Cross References

This section cited in 31 Pa. Code § 89.771 (relating to applicability and scope).

§ 89.789. Prohibition against preexisting conditions, waiting periods, elimination periods and probationary periods in replacement policies or certificates.

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

(b) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least 6 months,

the replacing policy may not provide a time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

Source

The provisions of this § 89.789 adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841.

Cross References

This section cited in 31 Pa. Code § 89.778 (relating to open enrollment).

§ 89.790. Guaranteed issue for eligible persons.

(a) *Guaranteed issue*.

(1) Eligible persons are those individuals described in subsection (b) who, seek to enroll under the policy during the period specified in subsection (c), and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment 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 (e) 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)—(7):

(1) The individual is enrolled under an employee 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 employee 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 Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act (42 U.S.C.A. § 1395eee), and there are circumstances similar to those described as follows that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare Advantage plan:

(i) The certification of the organization or plan under this part has been terminated.

(ii) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(iii) 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).

(iv) 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 producer or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

(v) 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 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 a producer 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 Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost) (42 U.S.C.A. § 1395mm), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or any Medicare Select policy and the subsequent enrollment under this paragraph is terminated by the enrollee during the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment under section 1851(e) of the Social Security Act).

(6) The individual, upon first becoming eligible for benefits under Part A and enrolled in Part B, if eligible, of Medicare, enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program within 12 months after the effective date of enrollment.

(7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (e)(4).

(c) *Guaranteed issue time periods.*

(1) In the case of an individual described in subsection (b)(1), the guaranteed issue period begins on the later of one of the following:

(i) The date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation).

(ii) The date that the applicable coverage terminates or ceases; and ends 63 days thereafter.

(2) In the case of an individual described in subsection (b)(2), (3), (5) or (6) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(3) In the case of an individual described in subsection (b)(4)(i), the guaranteed issue period begins on the earlier of the following:

(i) The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any.

(ii) The date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

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

(5) In the case of an individual described in subsection (b)(7), the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

(6) In the case of an individual described in subsection (b) but not described in subsections (d)—(f), the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(d) *Extended medigap access for interrupted trial periods*.

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

(2) In the case of an individual described in subsection (b)(6) (or deemed to be so described, under this paragraph) whose enrollment with a plan or in a program described in subsection (b)(6) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in subsection (b)(6).

(3) For the purposes of subsection (b)(5) and (6), no enrollment of an individual with an organization or provider described in subsection (b)(5), or with a plan or in a program described in subsection (b)(6), may be deemed to be an initial enrollment under this paragraph after the 2-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

(e) *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, F (including F with a high deductible), K or L offered by an issuer.

(2) Subsection (b)(5) is one of the following:

(i) Subject to subparagraph (ii), 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).

(ii) After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, one of the following:

(A) The policy available from the same issuer but modified to remove outpatient prescription drug coverage.

(B) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer.

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

(4) Subsection (b)(7) is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F, (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

(f) *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.

Authority

The provisions of this § 89.790 amended under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412).

Source

The provisions of this § 89.790 adopted January 8, 1999, effective January 9, 1999, 29 Pa.B. 172; amended May 5, 2000, effective May 6, 2000, 30 Pa.B. 2229; amended December 29, 2000, effective December 30, 2000, 30 Pa.B. 6886; amended November 22, 2002, effective November 23, 2002, apply retroactively to October 24, 2002, 32 Pa.B. 5743; amended May 6, 2005, effective May 7, 2005, 35 Pa.B. 2729. Immediately preceding text appears at serial pages (294377) to (294381).

Cross References

This section cited in 31 Pa. Code § 89.777c (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); and 31 Pa. Code § 89.778 (relating to open enrollment).

§ 89.791. Prohibition against use of genetic information and requests for genetic testing.

(a) This section applies to all Medicare supplement policies with policy years beginning on or after May 21, 2009.

(b) For purposes of this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:

Issuer—The issuer of a Medicare supplement policy or certificate as defined in § 89.772. This term includes a third party administrator, or other person acting for or on behalf of the issuer.

Family member—A first-degree, second-degree, third-degree or fourth-degree relative of an individual.

Genetic counseling—Obtaining, interpreting, or assessing genetic information.

Genetic information—Except for the sex or age of an individual, information regarding:

(i) Genetic tests of an individual or individual's family member.

(ii) The manifestation of a disease or disorder in an individual's family member.

(iii) An individual's request for, or receipt of, genetic services.

(iv) Participation in clinical research involving genetic services by an individual or an individual's family member.

(v) When an individual or family member is a pregnant woman, any reference to information of any fetus carried by the woman.

(vi) Information of any embryo legally held by an individual or family member utilizing reproductive technology.

Genetic services—A genetic test, genetic counseling or genetic education.

Genetic test—An analysis of human DNA, RNA, chromosomes, proteins or metabolites, that detect genotypes, mutations or chromosomal changes. The term does not include an analysis of proteins or metabolites that does not detect genotypes, mutations or chromosomal changes or an analysis of proteins or metabolites directly related to a manifested disease, disorder, or pathological condition that may reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(c) An issuer of a Medicare supplement policy or certificate may not:

(1) Use an individual's genetic information to deny or condition the issuance or effectiveness of a policy or certificate to that individual, including the imposition of an exclusion of benefits based on a preexisting condition.

(2) Use an individual's genetic information to discriminate in the pricing of the policy or certificate, including the adjustment of premium rates.

(3) Request or require an individual or an individual's family member to undergo a genetic test, except the issuer may:

(i) Obtain and use the results of a genetic test in making a determination regarding payment, as defined for the purposes of applying regulations promulgated under Title XI Part C of the Social Security Act (42 U.S.C.A. §§ 1320d—1320d-9) and section 264 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C.A. § 1320d-2 note 2), consistent with paragraphs (1) and (2) if the issuer requests only the minimum amount of information necessary to accomplish the intended purpose.

(ii) Request, but not require, an individual or individual's family member to undergo a genetic test if the following conditions are met:

(A) The request is made under research that complies with 45 CFR Part 46 (relating to protection of human subjects), or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(B) The issuer clearly indicates to the individual, or the legal guardian of a minor child, to whom the request is made, that compliance with the request is voluntary and that noncompliance will have no effect on enrollment status or premium or contribution amounts.

(C) The issuer does not use genetic information collected or acquired under this clause for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

(D) The issuer notifies the HHS Secretary in writing that the issuer is conducting activities under the exception provided for under this subsection, including a description of the activities conducted.

(E) The issuer complies with other conditions as the HHS Secretary may, by regulation, require for activities conducted under this subparagraph.

(4) Request, require, or purchase genetic information for underwriting purposes to:

(i) Determine enrollment, eligibility or continued eligibility for benefits under a policy.

(ii) Compute premium contribution amounts under a policy.

(iii) Apply any preexisting condition exclusion under a policy.

(iv) Conduct any activity related to the creation, renewal or replacement of a contract of health insurance or health benefits.

(5) Request, require or purchase an individual's genetic information prior to that individual's enrollment under the policy in connection with enrollment. If an issuer obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning an individual, the request, requirement, or purchase is not a violation of this paragraph if the request, requirement or purpose does not violate paragraph (4).

(d) Nothing in subsection (c)(1) or (2) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

(1) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant.

(2) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under a group policy; provided that the manifestation of a disease or disorder in one individual may not also be used as genetic information about other group members and to further increase the premium for the group.

Authority

The provision of this § 89.791 issued under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412), the Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 100-275, 122 Stat. 2494 and the Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, 122 Stat. 881.

Source

The provisions of this § 89.791 adopted April 24, 2009, effective April 25, 2009, 39 Pa.B. 2086.

Subchapter L. CHILDHOOD IMMUNIZATION INSURANCE

Sec.

Authority

The provisions of this Subchapter L issued under the Childhood Immunization Insurance Act (40 P. S. §§ 3501—3508), unless otherwise noted.

Source

The provisions of this Subchapter L adopted February 3, 1995, effective February 4, 1995, 25 Pa.B. 511, unless otherwise noted.

§ 89.801. Authority and purpose; implementation.

(a) *Authority and purpose.* This subchapter is jointly promulgated by the Departments to implement the act under section 7 of the act (40 P. S. § 3507).

(b) *Implementation.* The Department has primary responsibility for the interpretation and implementation of §§ 89.803—89.805, 89.808 and 89.809. The Department of Health has primary responsibility for the interpretation and implementation of §§ 89.806 and 89.807 (relating to coverage of child immunizations; and immunizing agents, doses and AWPs).

§ 89.802. Definitions.

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

ACIP—The Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, United States Department of Health and Human Services.

AWP—Average wholesale price.

Act—The Childhood Immunization Insurance Act (40 P. S. §§ 3501—3508).

Child—An individual covered under a health insurance policy who is either the insured and under 21 years of age, or the insured's spouse and under 21 years of age, or a dependent child pursuant to the definitions of the policy.

Child immunization—The immunization of a child, in accordance with § 89.806 (relating to coverage of child immunizations). The immunization will be reimbursed at the rate of the cost of the immunization up to 150% of the AWP of the immunizing agent.

Departments—The Department of Health and the Insurance Department.

Health insurance policy—Except for specified disease policies, a group health insurance policy, contract or plan, or an individual policy, contract or plan with dependent coverage for children, which provides medical coverage on an expense-incurred, service or prepaid basis. The term includes the following:

(i) A health insurance policy or contract issued by a nonprofit corporation subject to 40 Pa.C.S. Chapters 61, 63 and 65 (relating to hospital plan corporations; professional health services plan corporations; and fraternal benefit societies).

(ii) A health service plan operating under the Health Maintenance Organization Act (40 P. S. §§ 1551—1568).

(iii) A health insurance policy, contract or plan issued by or to an entity not exempt from Pennsylvania law by virtue of the Employee Retirement Income Security Act of 1974 (ERISA) (Pub. L. No. 93-406, 88 Stat. 829),

including multiple employer welfare arrangements, as defined in section 3(40)(A) of that act (29 U.S.C.A. § 1002(40)(A)).

Immunization—The immunizing agent, as well as, its storage and its administration by a person authorized by law to administer an immunizing agent, and a procedure or material associated with the process of immunizing with the exception of a procedure or material employed due to a medical complication such as an adverse reaction to the immunizing agent.

Immunizing agent—An antigenic substance such as a vaccine or toxoid, or an antibody-containing preparation such as a globulin or antitoxin, when used to actively or passively immunize.

MMWR—The *Morbidity and Mortality Weekly Report* published by the Centers for Disease Control and Prevention, United States Department of Health and Human Services.

§ 89.803. Provision for coverage in policy.

A health insurance policy which is not exempt from this subchapter under § 89.809 (relating to exempt policies) and which is delivered, issued for delivery, renewed, extended or modified in this Commonwealth on or after November 22, 1992, shall include coverage for child immunizations.

Cross References

This section cited in 31 Pa. Code § 89.801 (relating to authority and purpose; implementation).

§ 89.804. Delivery of policy.

If a health insurance policy provides coverage or benefits to a resident of this Commonwealth it shall be deemed to be delivered in this Commonwealth regardless of whether the health care insurer issuing or delivering the policy is located within or outside of this Commonwealth.

Cross References

This section cited in 31 Pa. Code § 89.801 (relating to authority and purpose; implementation).

§ 89.805. Cost-sharing provisions in policy.

(a) *Applicability.* Child immunization coverage shall be subject to copayment and coinsurance provisions of a health insurance policy to the extent other medical services covered by the policy are subject to those provisions.

(b) *Exemption.* Child immunization coverage shall be exempt from deductible or dollar limit provisions in a health insurance policy. This exemption shall be explicitly provided for in the policy.

Cross References

This section cited in 31 Pa. Code § 89.801 (relating to authority and purpose; implementation).

§ 89.806. Coverage of child immunizations.

(a) *Policy coverage.*

(1) A health insurance policy which is not exempt from this subchapter under § 89.809 (relating to exempt policies) shall provide coverage for the cost of the immunization of a child, up to 150% of the AWP of the immunizing agent, if the immunization conforms with ACIP standards in effect on May 21, 1992, governing the issuance of ACIP recommendations for the immunization of children. Those standards are as follows:

(i) The immunization practice is based upon both published and unpublished scientific literature as a means to address the morbidity and mortality of the disease.

(ii) The immunization practice is based upon labeling and packaging inserts for the immunizing agent.

(iii) The immunizing agent is safe and effective.

(iv) The schedule for use of the immunizing agent is administratively feasible.

(2) ACIP recommendations pertaining to the immunization of children are published in the MMWR. The Department of Health will deem an ACIP recommendation pertaining to the immunization of children to satisfy the standards set forth in this subsection unless ACIP alters its standards for recommending immunizations for children by eliminating a standard in this subsection and the recommendation is issued pursuant to those changed standards. An immunization practice which is recommended by ACIP pursuant to only the altered standards is not subject to the insurance coverage set forth in this subsection. An immunization practice which is recommended by ACIP pursuant to standards in addition to the standards enumerated in this subsection shall be deemed to satisfy the standards in this subsection.

(b) *Notices.* The Department of Health will place a notice in the *Pennsylvania Bulletin* listing MMWR publications containing ACIP recommendations issued pursuant to the standards in subsection (a). The Department of Health will publish the initial notice contemporaneously with the publication of this subchapter. The Department of Health will update that list in a notice which it will publish in the *Pennsylvania Bulletin* within 30 days after ACIP publishes a recommendation in the MMWR pursuant to the standards in subsection (a). The Department of Health will recommend that the list set forth in the initial notice and the update to the list set forth in a later notice be codified in the *Pennsylvania Code*. See Appendix G.

(c) *Effective date of coverage.* The insurance coverage set forth in subsection (a) shall be effective November 22, 1992, for a child immunization practice recommended by ACIP which was published in the MMWR on or before that date. Thereafter, the insurance coverage described in subsection (a) shall include a child immunization practice recommended by ACIP effective on the date the ACIP recommendation which is issued under the standards in subsection (a) is published in the MMWR.

Cross References

This section cited in 31 Pa. Code § 89.801 (relating to authority and purpose; implementation); 31 Pa. Code § 89.802 (relating to definitions); 31 Pa. Code § 89.807 (relating to immunizing agents, doses and AWPs); 31 Pa. Code Chapter 89, Appendix G (relating to ACIP recommendations prescribing child immunization practices); and 31 Pa. Code Chapter 89, Appendix H (relating to immunizating agents and doses).

§ 89.807. Immunizing agents, doses and AWPs.

(a) One hundred fifty percent of the AWP of the immunizing agent that may be used in a child immunization in accordance with § 89.806 (relating to coverage of child immunizations) is to be calculated by taking 150% of the AWP of the purchase unit for the immunizing agent, using the AWP and purchase unit information contained in the *Blue Book American Druggist First Databank*

Annual Directory of Pharmaceuticals as revised in monthly updates prepared by the First Databank Directory of Pharmaceuticals, and then dividing by the number of doses comprising the purchase unit based upon the dose of the immunizing agent used in the child's immunization. Example: If the AWP of the purchase unit (15 dose 7.5 ml vial) of DTP, Lederle, TRI-IMMUNOL is $172.95, 150% of the AWP of an 0.5 ml dose of DTP, Lederle, TRI-IMMUNOL = 1.5 (150%) × $172.95 (AWP of the purchase unit) ÷ 15 (number of 0.5 ml doses in 7.5 ml vial) = $17.30.

(b) The Department of Health will place a notice in the *Pennsylvania Bulletin* which contains information on immunizing agents and doses which the Department of Health has extracted from ACIP recommendations issued under the standards in § 89.806(a). The Department of Health will publish the initial notice contemporaneously with the publication of this subchapter. The Department of Health will update the information in a notice which it will publish in the *Pennsylvania Bulletin* within 30 days after ACIP issues a recommendation pursuant to the standards in § 89.806(a). The Department of Health will recommend that the information contained in the initial notice and the update to that information contained in a later notice be codified in the *Pennsylvania Code*. The Department of Health will also periodically list AWPs for immunizing agents in a notice which it will publish in the *Pennsylvania Bulletin*. See Appendix H.

Cross References

This section cited in 31 Pa. Code § 89.801 (relating to authority and purpose; implementation); and 31 Pa. Code Chapter 89, Appendix H (relating to immunizing agents and doses).

§ 89.808. Filing requirements.

(a) An insurer shall submit to the Department, for its review and approval, a health insurance policy not exempt from this subchapter under § 89.809 (relating to exempt policies), which is to be delivered, issued for delivery, renewed, extended or modified on or after April 5, 1995. The policy shall contain the necessary provisions to bring it into compliance with the act and this subchapter.

(b) For each health insurance policy issued prior to April 5, 1995, which is not exempt from this subchapter under § 89.809 (relating to exempt policies), the insurer shall submit to the Insurance Department, by June 5, 1995, for its review and approval, a rider or endorsement to bring the policy into compliance with the act and this subchapter.

(c) An insurer shall submit to the Department, for its review and approval, in accordance with the applicable statutory authority, a change in premium rates which is made necessary and appropriate by the insurer's compliance with the act and this subchapter.

Cross References

This section cited in 31 Pa. Code § 89.801 (relating to authority and purpose; implementation).

§ 89.809. Exempt policies.

The following types of health insurance policies are not required to provide child immunization coverage:

(1) An indemnity contract in which payment is a specified amount without regard to the actual expense incurred, a contract which provides reimbursement for hospital expenses only, a contract which covers only dental or vision expenses, an accident-only policy, a long-term care insurance policy and a Medicare supplement policy.

(2) A contract which is noncancelable guaranteed renewable which was issued prior to November 22, 1992.

(3) A contract covering a resident of this Commonwealth who is employed outside this Commonwealth by an employer that maintains health insurance for the individual as an employment benefit.

Cross References

This section cited in 31 Pa. Code § 89.801 (relating to authority and purpose; implementation); 31 Pa. Code § 89.803 (relating to provision for coverage in policy); 31 Pa. Code § 89.806 (relating to coverage of child immunizations); and 31 Pa. Code § 89.808 (relating to filing requirements).

Subchapter M. [Reserved]

Sec.
89.901—89.921. [Reserved].

Source

The provisions of this Subchapter M adopted December 9, 1994, effective December 10, 1994, 24 Pa.B. 6229; reserved March 15, 2002, effective March 16, 2002, 32 Pa.B. 1475. Immediately preceding text appears at serial text pages (214654) to (214660), (284865) to (284867) and (214663) to (214675).

§§ 89.901—89.921. [Reserved].

Notes of Decisions

Issue of Fact

There is a genuine issue of material fact whether insurer engaged in postclaim underwriting, where insurer permitted insured to enroll during period of open enrollment, insured purportedly provided insurer with full disclosure of his condition at time of enrollment, and insurer later denied coverage for reason of the allegedly disclosed condition. That issue of fact precludes an entry of summary judgment as to whether the insurer violated the provision prohibiting postclaim underwriting. *Schneider v. UNUM Life Insurance Company of America*, 149 F. Supp.2d 169 (E.D. Pa. 2001).

APPENDIX A. [Reserved]

Source

The provisions of this Appendix A adopted September 15, 1989, effective September 16, 1989, 19 Pa.B. 3945; corrected September 22, 1989, effective September 16, 1989, 19 Pa.B. 4056; reserved November 30, 1990, effective December 1, 1990, 20 Pa.B. 5928. Immediately preceding text appears at serial pages (143022) to (143027).

APPENDIX B. [Reserved]

Source

The provisions of this Appendix B adopted September 15, 1989, effective September 16, 1989, 19 Pa.B. 3945; corrected September 22, 1989, effective September 16, 1989, 19 Pa.B. 4056; reserved November 30, 1990, effective December 1, 1990, 20 Pa.B. 5928. Immediately preceding text appears at serial pages (143028) and (146519) to (146520).

APPENDIX C. [Reserved]

Source

The provisions of this Appendix C adopted September 15, 1989, effective September 16, 1989, 19 Pa.B. 3945; reserved November 30, 1990, effective December 1, 1990, 20 Pa.B. 5928. Immediately preceding text appears at serial pages (143031) to (143033).

APPENDIX D. [Reserved]

Source

The provisions of this Appendix D adopted November 30, 1990, effective December 1, 1990, 20 Pa.B. 5928; reserved July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841. Immediately preceding text appears at serial pages (154999) to (155002).

[Next page is 89-143.]

APPENDIX E. [Reserved]

Source

The provisions of this Appendix E adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841; amended May 10, 1996, effective May 11, 1996, 26 Pa.B. 2196; amended May 5, 2000, effective May 6, 2000, 30 Pa.B. 2229; amended May 6, 2005, effective May 7, 2005, 35 Pa.B. 2729. Immediately preceding text appears at serial pages (266443) to (266446) and (296145).

APPENDIX F

FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due: March 1, annually

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

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

Source

The provisions of this Appendix F adopted July 24, 1992, effective July 25, 1992, 22 Pa.B. 3841.

APPENDIX G
ACIP Recommendations Prescribing Child Immunization Practices

Under § 89.806(a) (relating to coverage of child immunizations), the Department of Health has established a list of citations to recommendations of the Advisory Committee on Immunization Practices (ACIP), Centers for Disease Control and Prevention, United States Department of Health and Human Services. The child immunization practices specified in those recommendations are subject to the insurance coverage required by the Childhood Immunization Insurance Act (act) (40 P. S. §§ 3501—3508) as explained in § 89.806(a).

ACIP recommendations prescribing immunization practices are published in the *Morbidity and Mortality Weekly Report* (MMWR), a weekly publication of the United States Department of Health and Human Services. MMWR citations to the relevant ACIP recommendations are listed in this appendix. The effective date of insurance coverage required by the act for each ACIP recommended child immunization practice can be ascertained by consulting § 89.806(c).

If new ACIP recommendations that satisfy the standards in § 89.806(a) are published in the MMWR, they will become effective upon publication in the MMWR. The Department of Health will arrange for an update notice to appear in the *Pennsylvania Bulletin* within 30 days after the MMWR publication date of each future ACIP recommendation that satisfies the standards in § 89.806(a). The new recommendations will be codified in this appendix.

(1) ''General Recommendations on Immunizations,'' MMWR, January 28, 1994/Vol. 43/No. RR-1, pages 1—38.

(2) ''Diphtheria, Tetanus, and Pertussis: Recommendations for Vaccine Use and Other Preventive Measures,'' MMWR, August 8, 1991/Vol. 40/No. RR-10, pages 1—28, with the exception of materials relating to Diphtheria Antitoxin.

(3) ''Pertussis Vaccination: Acellular Pertussis Vaccine for Reinforcing and Booster Use-Supplementary ACIP Statement,'' MMWR, February 7, 1992/Vol. 41/No. RR-1, pages 1—10.

(4) ''Pertussis Vaccination: Acellular Pertussis Vaccine for the Fourth and Fifth Doses of the DTP Series—Update to Supplementary ACIP Statement,'' MMWR, October 9, 1992/Vol. 41/No. RR-15, pages 1—5.

(5) ''Measles Prevention: Recommendations of the Immunization Practices Advisory Committee,'' MMWR, December 29, 1989/Vol. 38/No. S-9, pages 1—13.

(6) ''Mumps Prevention,'' MMWR, June 9, 1989/Vol. 38/No. 22, pages 388—392, 397—400.

(7) ''Rubella Prevention,'' MMWR, November 23, 1990/Vol. 39/No. RR-15, pages 1—18.

(8) ''Poliomyelitis Prevention,'' MMWR, January 29, 1982/Vol. 31/No. 3, pages 22—26, 31—34.

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(9) ''Poliomyelitis Prevention: Enhanced-Potency Inactivated Poliomyelitis Vaccine—Supplementary Statement,'' MMWR, December 11, 1987/Vol. 36/No. 48, pages 795—798.

(10) ''Haemophilus b Conjugate Vaccines for Prevention of Haemophilus influenzae Type b Disease Among Infants and Children Two Months of Age and Older,'' MMWR, January 11, 1991/Vol. 40/No. RR-1, pages 1—7.

(11) ''Recommendations for Use of Haemophilus b Conjugate Vaccines and a Combined Diphtheria, Tetanus, Pertussis, and Haemophilus b Vaccine,'' MMWR, September 17, 1993/Vol. 42/No. RR-13, pages 1—15.

(12) ''Meningococcal Vaccines,'' MMWR, May 10, 1985/Vol. 34/No. 18, pages 255—259.

(13) ''Hepatitis B Virus: A Comprehensive Strategy for Eliminating Transmission in the United States Through Universal Childhood Vaccination,'' MMWR, November 22, 1991/Vol. 40/No. RR-13, pages 1—25.

(14) ''Protection Against Viral Hepatitis,'' MMWR, February 9, 1990/Vol. 39/No. RR-2, pages 1—21.

(15) ''Update: Recommendations to Prevent Hepatitis B Virus Transmission—United States,'' MMWR, August 9, 1995/Vol. 44/No. 30, pages 574—575.

(16) ''Prevention and Control of Influenza,'' MMWR, May 3, 1996/Vol. 45/No. RR-5, pages 1—24.

(17) ''Pneumococcal Polysaccharide Vaccine,'' MMWR, February 10, 1989/Vol. 38/No. 5, pages 64-68, 73—76.

(18) ''Rabies Prevention-United States, 1991,'' MMWR, March 22, 1991/Vol. 40/No. RR-3, pages 1—19.

(19) ''Varicella-Zoster Immune Globulin for the Prevention of Chickenpox,'' MMWR, February 24, 1984/Vol. 33/No. 7, pages 84—90, 95—100.

(20) ''Prevention of Varicella,'' MMWR, July 12, 1996/Vol. 45/No. RR-11, pages 1—25.

(21) ''Pertussis Vaccination: Use of Acellular Pertussis Vaccines Among Infants and Young Children,'' *MMWR*, March 28, 1997/Vol. 46/No. RR-7.

(22) ''Prevention of Pneumococcal Disease,'' *MMWR*, April 4, 1997/Vol. 46/No. RR-8.

(23) ''Measles, Mumps, and Rubella—Vaccine Use and Strategies for Elimination of Measles, Rubella, and Congenital Rubella Syndrome and Control of Mumps,'' *MMWR*, May 22, 1998/Vol. 47/No. RR-8.

(24) ''Human Rabies Prevention—United States, 1999,'' *MMWR*, January 8, 1999/Vol 48/No. RR-1.

(25) ''Prevention of Varicella Updated,'' *MMWR*, May 28, 1999/Vol. 48/No. RR-6.

(26) ''Prevention of Hepatitis A Through Active or Passive Immunization,'' *MMWR*, October 1, 1999/Vol. 48/No. RR-12.

(27) ''Poliomyelitis Prevention in the United States,'' *MMWR*, May 19, 2000/Vol. 49/No. RR-5.

(28) ''Prevention and Control of Meningococcal Disease and Meningococcal Disease and College Students,'' *MMWR*, June 30, 2000/Vol. 49/No. RR-7.

(29) ''Preventing Pneumococcal Disease Among Infants and Young Children,'' *MMWR*, October 6, 2000/Vol. 49/No. RR-9.

(30) ''Use of Diphtheria Toxoid-Tetanus Toxoid-Acellular Pertussis Vaccine as a Five-Dose Series,'' *MMWR*, November 17, 2000/Vol. 39/No.13.

(31) ''Prevention and Control of Influenza,'' *MMWR*, April 20, 2001/Vol 50/No. RR-4.

(32) ''Notice to Readers: FDA Approval for a Combined Hepatitis A and B Vaccine,'' MMWR, September 21, 2001 /Vol. 50 / No.37.

(33) ''Simultaneous Administration of Varicella Vaccine and Other Recommended Childhood Vaccines—United States, 1995-1999,'' MMWR, November 30, 2001 / Vol. 50 / No.47.

(34) ''General Recommendations on Immunization,'' MMWR, February 8, 2002 / Vol. 51 / No. RR-2.

(35) ''Prevention and Control of Influenza,'' MMWR, April 12, 2002 / Vol. 51 / No.RR-3.

(36) ''Notice to Readers: Resumption of Routine Schedule for Tetanus and Diphtheria Toxoids,'' June 21, 2002/Vol. 51/No. 24.

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(38) ''Notice to Readers: Resumption of Routine Schedule for Diphtheria and Tetanus Toxoids and Acellular Pertussis Vaccine and for Measles, Mumps, and Rubella Vaccine,'' July 12, 2002/Vol. 51/No. 27.

(39) ''Hepatitis B Vaccination Among High-Risk Adolescents and Adults—San Diego, California, 1998—2001,'' July 19, 2002/Vol. 51/No. 28.

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(45) ''Surveillance for Safety After Immunization: Vaccine Adverse Event Reporting System (VAERS)—United States, 1991—2001,'' January 24, 2003/Vol. 52/No. SS—1.

(46) ''Pneumococcal Vaccination for Cochlear Implant Candidates and Recipients: Updated Recommendations of the Advisory Committee on Immunization Practices,'' August 8, 2003/Vol. 52/No. 31.

(47) ''Notice to Readers: Supplemental Recommendations About the Timing of Influenza Vaccination, 2003-04 Season,'' August 22, 2003/Vol. 52/No. 33.

(48) ''Notice to Readers: FDA Approval of Diphtheria and Tetanus Toxoids and Acellular Pertussis Vaccine Adsorbed, (INFANRIX®) for Fifth Consecutive DTaP Vaccine Dose,'' September 26, 2003/Vol. 52/No. 38.

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(50) ''Notice to Readers: Limited Supply of Pneumococcal Conjugate Vaccine,'' December 19, 2003/Vol. 52/No. 50.

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(56) ''Notice to Readers: National Infant Immunization Week—April 24 through 30, 2005,'' April 15, 2005/Vol. 54/No. 14.

(57) ''Update: Influenza Activity—United States, 2004-05 Season Notice to Readers,'' April 8, 2005/Vol. 54/No. 13.

(58) ''Estimated Influenza Vaccination Coverage Among Adults and Children—United States, September 1, 2004, through January 31, 2005,'' April 1, 2005/Vol. 54/No. 12.

(59) ''Hepatitis A Vaccination Coverage Among Children Aged 24-35 Months—United States, 2003'' February 18, 2005/Vol. 54/No. 6.

(60) ''Notice to Readers: Improved Supply of Meningococcal Conjugate Vaccine, Recommendation to Resume Vaccination of Children Aged 11—12 Years,'' November 3, 2006/Vol. 55/No. 43.

(61) ''Update: Guillain Barré Syndrome Among Recipients of Menactra® Meningococcal Conjugate Vaccine—United States, June 2005—September 2006,'' October 20, 2006/Vol. 55/No. 41.

(62) ''Pertussis Outbreak in an Amish Community—Kent County, Delaware, September 2004—February 2005,'' August 4, 2006/Vol. 55/No. 30.

(63) ''Varicella Outbreak Among Vaccinated Children—Nebraska, 2004,'' August 4, 2006/Vol. 55/No. 30.

(64) ''Notice to Readers: Expansion of Use of Live Attenuated Influenza Vaccine (FluMist®) to Children Aged 2—4 Years and Other FluMist Changes for the 2007-2008 Influenza Season,'' November 23, 2007/Vol. 56/No. 46.

(65) ''Update: Prevention of Hepatitis A After Exposure to Hepatitis A Virus and in International Travelers. Updated Recommendations of the Advisory Committee on Immunization Practices (ACIP),'' October 19, 2007/Vol. 56/No. 41.

(66) ''Notice to Readers: FDA Approval of an Alternate Dosing Schedule for a Combined Hepatitis A and B Vaccine (Twinrix®),'' October 12, 2007/Vol. 56/No. 40.

(67) ''Influenza Vaccination Coverage Among Children Aged 6—23 Months—United States, 2005-2006 Influenza Season,'' September 21, 2007/ Vol. 56/No. 37.

(68) ''Influenza Vaccination Coverage Among Children Aged 6—59 Months—Six Immunization Information System Sentinel Sites, 2006-2007 Influenza Season''

(69) ''National, State, and Local Area Vaccination Coverage Among Children Aged 19—35 Months—United States, 2006,'' August 31, 2007/Vol. 56/No. 34.

(70) ''National Vaccination Coverage Among Adolescents Aged 13—17 Years—United States, 2006.''

(71) ''Notice to Readers: Revised Recommendations of the Advisory Committee on Immunization Practices to Vaccinate All Persons Aged 11—18 Years with Meningococcal Conjugate Vaccine,'' August 10, 2007/Vol. 56/No. 31.

(72) ''Hepatitis A Vaccination Coverage Among Children Aged 24—35 Months—United States, 2004-2005,'' July 13, 2007/Vol. 56/No. 27.

(73) ''Newborn Hepatitus B Vaccination Coverage Among Children Born January 2003—June 2005—United States'' August 1, 2008/Vol. 57/No. 30.

(74) ''Prevention and Control of Influenza'' August 8, 2008/Vol. 57/No. RR07.

(75) ''Update: Measles—United States, January—July 2008'' August 22, 2008/Vol. 57/No. 33.

(76) ''National, State and Local Area Vaccination Coverge Among Children Aged 19—35 Months'' September 5, 2008/Vol. 57/No. 35.

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(81) ''Updated Recommendations for Isolation of Persons with Mumps'' October 10, 2008, Vol. 57/No. 40.

(82) ''Vaccination Coverage Among Adolescents Aged 13—17 Years—United States, 2007'' October 10, 2008/Vol. 57/No. 40.

(83) ''Rotavirus Surveillance—Worldwide, 2001—2008'' November 21, 2008/Vol. 57/No. 46.

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(84) ''Continued Shortage of *Haemophilus influenzae* Type b (Hib) Conjugate Vaccines and Potential Implications for Hib Surveillance—Unites States, 2008''/Vol. 57/No. 46.

(85) ''Implementation of Newborn Hepatitis B Vaccination—Worldwide, 2006''/November 21, 2008/Vol. 57/No. 46.

(86) ''Progress in Global Measles Control and Mortality Reduction, 2000—2007''/December 5, 2008/Vol. 57/No. 48.

(87) ''Evaluation of Rapid Influenza Diagnostic Tests for Detection of Novel Influenza a (H1N1) Virus—United States, 2009''/August 7, 2009/Vol. 58/No. 30.

(88) ''Updated Recommendations of the Advisory Committee on Immunization Practices (ACIP) Regarding Routine Poliovirus Vaccination''/August 7, 2009/Vol. 58/No. 30.

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(91) ''Oseltamivir-Resistant 2009 Pandemic Influenza A (H1N1) Virus Infection in Two Summer Campers Receiving Prophylaxis—North Carolina, 2009''/September 11, 2009/Vol. 58/No. 35.

(92) ''National, State, and Local Area Vaccination Coverage Among Adolescents Aged 13—17 Years—United States, 2008''/September 18, 2009/Vol. 58/No. 36.

(93) ''Updated Recommendations from the Advisory Committee on Immunization Practices (ACIP) for Use of Hepatitis A Vaccine in Close Contacts of Newly Arriving International Adoptees''/September 18, 2009/Vol. 58/No. 36.

(94) ''Licensure of a Haemophilus influenzae Type b (Hib) Vaccine (Hiberix) and Updated Recommendations for Use of Hib Vaccine''/September 18, 2009/Vol. 58/No. 36.

(95) ''Updated Recommendation from the Advisory Committee on Immunization Practices (ACIP) for Revaccination of Persons at Prolonged Increased Risk for Meningococcal Disease''/September 25, 2009/Vol. 58/No. 37.

(96) ''Influenza Vaccination Coverage Among Children Aged 6—23 Months—United States, 2007—08 Influenza Season''/October 2, 2009/Vol. 58/No. 38.

(97) ''Influenza Vaccination Coverage Among Children and Adults—United States, 2008—09 Influenza Season''/October 9, 2009/Vol. 58/No. 39.

(98) ''Norovirus Outbreaks on Three College Campuses—California, Michigan and Wisconsin, 2008''/October 9, 2009/Vol. 58/No. 39.

(99) ''Reduction in Rotavirus After Vaccine Introduction—United States, 2000—2009''/October 23, 2009/Vol. 58/No. 41.

(100) ''Effectiveness of 2008—09 Trivalent Influenza Vaccine Against 2009 Pandemic Influenza A (H1N1)—United States, May—June 2009''/November 13, 2009/Vol. 58/No. 44.

(101) ''Mumps Outbreak—New York, New Jersey, Quebec, 2009''/November 20, 2009/Vol. 58/No. 45.

(102) ''Safety of Influenza A (H1N1) 2009 Monovalent Vaccines—United States, October 1—November 24, 2009''/December 11, 2009''/Vol. 58/No. 48.

(103) ''Recommended Adult Immunization Schedule—United States, 2010''/January 15, 2010/Vol. 59(01)/1-4.

(104) ''Update: Influenza Activity—United States, August 30, 2009-January 9, 2010''/January 22, 2010/Vol. 59(02)/38-43.

(105) ''Update: Mumps Outbreak—New York and New Jersey, June 2009-January 2010''/February 12, 2010/Vol. 59(05)/125-129.

(106) ''Progress in Immunization Information Systems—United States, 2008''/February 12, 2010/Vol. 59(05)/133-135.

(107) ''Licensure of a 13-Valent Pneumococcal Conjugate Vaccine (PCV13) and Recommendations for Use Among Children-Advisory Committee on Immunization Practices (ACIP), 2010''/March 12, 2010/Vol. 59(09)/258-261.

(108) ''Prevnar 13 Licensure''/March 12, 2010/Vol. 59(09)/258-261.

(109) ''Licensure of a Meningococcal Conjugate Vaccine (Menveo) and Guidance for Use Advisory Committee on Immunization Practices (ACIP), 2010''/March 12, 2010/Vol. 59(09)/273.

(110) ''2009 Pandemic Influenza A (H1N1) in Pregnant Women Requiring Intensive Care—New York City, 2009''/March 26, 2010/Vol 59(11)/321-326.

(111) ''Interim Results: State-Specific Influenza A (H1N1) 2009 Monovalent Vaccination Coverage—United States, October 2009 to January 2010''/April 2, 2010/Vol. 59(12)/363-368.

(112) ''Interim Results: State-Specific Seasonal Influenza Vaccination Coverage—United States, August 2009 to January 2010''/April 30, 2010/Vol. 59(16)/477-484.

(113) ''FDA Licensure of Bivalent Human Papillomavirus Vaccine (HPV2, Cervarix) for Use in Females and Updated HPV Vaccination Recommendations from the Advisory Committee on Immunization Practices (ACIP)''/May 28, 2010/Vol. 59(20)/626-629.

(114) ''FDA Licensure of Quadrivalent Human Papillomavirus Vaccine (HPV4, Gardasil) for Use in Males and Guidance from the Advisory Committee on Immunization Practices (ACIP)''/May 28, 2010/Vol. 59(20)/630-632.

(115) ''Preliminary Results: Surveillance for Guillain-Barré Syndrome After Receipt of Influenza A (H1N1) 2009 Monovalent Vaccine—United States, 2009-2010''/June 4, 2010/Vol. 59(21)/657-661.

(116) ''Addition of Severe Combined Immunodeficiency as a Contraindication for Administration of Rotavirus Vaccine''/June 11, 2010/Vol. 59(22)/687-688.

(117) ''Hepatitis A Vaccination Coverage Among U.S. Children Aged 12-23 Months—Immunization Information System Sentinel Sites, 2006-2009''/July 2, 2010/Vol. 59/No. 25.

(118) ''Seasonal Influenza Vaccination Coverage Among Children Aged 6 Months-18 Years—Eight Immunization Information System Sentinel Sites, United States, 2009-10 Influenza Season''/October 8, 2010/Vol. 59/No. 39.

(119) ''Prevention of Pneumococcal Disease Among Infants and Children—Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine''/December 10, 2010/Vol. 59/No. RR11.

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(120) ''Updated Recommendations for Use of Meningococcal Conjugate Vaccines-Advisory Committee on Immunization Practices (ACIP), 2010''/January 28, 2011/Vol. 60/No. 3.

(121) ''Recommended Immunization Schedules for Persons Aged 0 Through 18 Years—United States, 2011''/February 11, 2011/Vol. 60/No. 5.

(122) ''Measles Imported by Returning U.S. Travelers Aged 6-23 Months, 2001-2011''/April 8, 2011/Vol. 60/No. 1.

(123) ''Measles-United States, January-May 20, 2011''/May 27, 2011/Vol. 60/No. 20.

(124) ''Licensure of a Meningococcal Conjugate Vaccine for Children Aged 2 Through 10 Years and Updated Booster Dose guidance for Adolescents and Other Persons at Increased Risk for Meningococcal Disease—Advisory Committee on Immunization Practices (ACIP), 2011''/August 5, 2011/Vol. 60/No. 30.

(125) ''National and State Vaccination Coverage Among Adolescents Aged 13 Through 17 Years—United States, 2010''/August 26, 2011/Vol. 60/No. 33.

(126) ''National and State Vaccination Coverage Among Children Aged 19-35 Months—United States, 2010''/September 2, 2011/Vol. 60/No. 34.

(127) ''Recommendation of the Advisory Committee on Immunization Practices (ACIP) for Use of Quadrivalent Meningococcal Conjugate Vaccine (MenACWY-D) Among Children Aged 9 Through 23 Months at Increased Risk for Invasive Meningococcal Disease''/October 14, 2011/Vol. 60/No. 40.

(128) ''Invasive Pneumococcal Disease and 13-Valent Pneumococcal Conjugate Vaccine (PCV13) Coverage Among Children Aged ≤59 Months—Selected United States Regions, 2010-2011''/November 4, 2011/Vol. 60/No. 43.

(129) ''Prevention and Control of Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP)—United States, 2012-13 Influenza Season''/August 17, 2012/Vol. 61/No. 32.

(130) ''National and State Vaccination Coverage Among Adolescents Aged 13-17 Years—United States, 2011''/August 31, 2012/Vol. 61/No. 34.

(131) ''Vaccination Coverage Among Children in Kindergarten—United States, 2011-12 School Year''/August 24, 2012/Vol. 61/No. 33.

(132) ''National, State, and Local Area Vaccination Coverage Among Children Aged 19-35 Months—United States, 2011''/September 7, 2012/Vol. 61/No. 35.

(133) ''Prevention and Control of Meningococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP)''/March 22, 2013/Vol. 62/No. RR02.

(134) ''Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine Among Children Aged 6—18 Years with Immunocompromising Conditions: Recommendations of the Advisory Committee on Immunization Practices (ACIP)''/June 28, 2013/Vol. 62/No. 25.

Source

The provisions of this Appendix G adopted February 3, 1995, effective February 4, 1995, 25 Pa.B. 511; amended August 16, 1996, effective August 17, 1996, 26 Pa.B. 3958; amended August 10, 2001, effective August 11, 2001, 31 Pa.B. 4498; amended October 25, 2002, effective October 26, 2002, 32 Pa.B. 5352; amended March 14, 2003, effective March 15, 2003, 33 Pa.B. 1418; amended April 16, 2004, effective April 17, 2004, 34 Pa.B. 2135; amended September 17, 2004, effective September 18, 2004, 34 Pa.B. 5218; amended September 16, 2005, effective September 17, 2005, 35 Pa.B. 5190; amended January 19, 2007, effective January 20, 2007, 37 Pa.B. 372; amended December 21, 2007, effective December 22, 2007, 37 Pa.B. 6851; amended February 27, 2009, effective February 28,

2009, 39 Pa.B. 1167; amended February 5, 2010, effective February 6, 2010, 40 Pa.B. 760; amended September 17, 2010, effective September 18, 2010, 40 Pa.B. 5404; amended March 4, 2011, effective March 5, 2011, 41 Pa.B. 1263; amended October 28, 2011, effective October 29, 2011, 41 Pa.B. 5821; amended April 6, 2012, effective April 7, 2012, 42 Pa.B. 1929; amended February 1, 2013, effective February 2, 2013, 43 Pa.B. 745; amended October 11, 2013, effective October 12, 2013, 43 Pa.B. 6079. Immediately preceding text appears at serial pages (311232), (296147) to (296148), (342055) to (342056), (356173) to (356174) and (365547).

Cross References

This appendix cited in 31 Pa. Code § 89.806 (relating to coverage of child immunizations).

APPENDIX H
Immunizing Agents and Doses

Under § 89.807(b) (relating to immunizing agents, doses and AWPs), the Department of Health has established a table setting forth immunizing agent and dose information extracted from recommendations of the Advisory Committee on Immunization Practices (ACIP), Centers for Disease Control and Prevention, United States Department of Health and Human Services. The relevant ACIP recommendations are those which prescribe child immunization practices and are currently in effect. The child immunization practices specified in those recommendations are subject to the insurance coverage required by the Childhood Immunization Insurance Act (act) (40 P. S. §§ 3501—3508) as explained in § 89.806(a) (relating to coverage of child immunizations).

Under § 89.807(b), the Department of Health is to also periodically publish a notice in the *Pennsylvania Bulletin* setting forth the AWPs for dosage units of immunizing agents which the relevant ACIP recommendations prescribe for use in child immunizations. The AWPs are calculated as described in § 89.807(a) and should be recalculated monthly as explained in that subsection.

The immunizing agent and dose information is set forth in this appendix. This information is subject to change. It may be superseded, as explained in §§ 89.806(a) and 89.807(a).

The Department of Health will arrange for an update notice to appear in the *Pennsylvania Bulletin* within 30 days after a new ACIP recommendation which satisfies the standards in § 89.806(a) is published in the *Morbidity and Mortality Weekly Report*, a weekly publication of the United States Department of Health and Human Services. The new recommendations will be codified in this appendix.

2011 List of Immunizing Agents and Average Wholesale Prices

Product Name, Company	*Brand/Product Name*	*NDC Number*	*Unit*	*Dose*	*AWP/Dose**
Diphtheria Tetanus acellular Pertussis Vaccine (DTaP):					
sanofi Pasteur	Tripedia	49281-0298-10	10 x 1	0.5 ml	$27.97
sanofi pasteur	Daptacel	49281-0286-10	10 x 1	0.5 ml	$28.83
GlaxoSmithKline	Infanrix—syringe	58160-0812-46	10 x 1	0.5 ml	$23.02
GlaxoSmithKline	Infanrix	58160-0810-11	10 x 1	0.5 ml	$24.70
Tetanus Diphtheria acellular Pertussis Vaccine (TdaP):					
sanofi pasteur	Adacel	49281-0400-10	10 x 1	0.5 ml	$46.15
sanofi pasteur	Adacel	49281-0400-15	5 x 1	0.5 ml	$46.15
GlaxoSmithKline	Boostrix	58160-0842-11	10 x 1	0.5 ml	$44.61
GlaxoSmithKline	Boostrix—syringe	58160-0842-51	10 x 1	0.5 ml	$44.61
Diphtheria Tetanus pediatric Vaccine (DT pediatric):					
sanofi pasteur	DT Pediatric	49281-0278-10	10 x 1	0.5 ml	$37.27
Diphtheria Tetanus acellular Pertussis/Haemophilus Influenzae B (DTaP-HIB):					
sanofi pasteur	TriHIBit	49281-0597-05	5 x 1	0.5 ml	$56.58
Tetanus Diphtheria adult Vaccine (Td adult):					
sanofi pasteur	Decavac	49281-0291-83	10 x 1	0.5 ml	$24.17
sanofi pasteur	Decavac	49281-0291-10	10 x 1	0.5 ml	$24.17
Merck & Co.	Td Vaccine	14362-0111-03	10 x 1	0.5 ml	$22.34
Diphtheria, Tetanus, acellular Pertussis, Haemophilus Influenzae B, Polio (DTaP, HIB, IPV):					
sanofi pasteur	Pentacel	49281-0510-05	5 x 1	0.5 ml	$92.22
Diphtheria, Tetanus, acellular Pertussis, Polio (DTap, IPV):					
GlaxoSmithKline	Kinrix—syringe	58160-0812-51	10 x 1	0.5 ml	$57.00
GlaxoSmithKline	Kinrix	58160-0812-11	10 x 1	0.5 ml	$57.00
Diphtheria, Tetanus, acellular Pertussis, Hepatitis B, Polio (DTaP, Hep B, IPV):					
GlaxoSmithKline	Pediarix	58160-0811-11	10 x 1	0.5 ml	$84.12

Product Name, Company	*Brand/Product Name*	*NDC Number*	*Unit*	*Dose*	*AWP/Dose**
GlaxoSmithKline	Pediarix—syringe	58160-0811-46	5 x 1	0.5 ml	$ 84.12
Tetanus Toxoid:					
sanofi pasteur	Tetanus toxoid	49281-0820-10	10 x 1	0.5 ml	$ 37.03
Haemophilus Influenzae Type B Vaccine (HIB):					
sanofi pasteur	ActHIB	49281-0545-05	5 x 1	10 mcg	$ 29.00
Merck & Co.	Pedvax HIB	00006-4897-00	10 x 1	7.5 mcg	$ 27.32
GlaxoSmithKline	Hiberix	58160-0806-05	10 x 1	0.5 ml	$ 8.66
Injectable Polio Vaccine Inactivated (Salk Enhanced IPV):					
sanofi pasteur	IPOL	49281-0860-55	10 x 1	0.5 ml	$ 30.36
sanofi pasteur	IPOL	49281-0860-10	5.0 ml	0.5 ml	$ 30.36
Measles Mumps Rubella Vaccine (MMR):					
Merck & Co.	MMR II	00006-4681-00	10 x 0.5	0.5 ml	$ 55.40
Measles Vaccine (Rubeola):					
Merck & Co.	Attenuvax	0006-4589-00	10 x 0.5	0.5 ml	$ 20.48
Meningococcal Conjugate Vaccine (MCV4):					
sanofi pasteur	Menactra	49281-0589-05	5 x 1	0.5 ml	$127.64
sanofi pasteur	Menactra	49281-0589-15	5 x 1	0.5 ml	$127.64
Novartis	Menveo	46028-0208-01	5 x 1	0.5 ml	$106.49
Meningococcal Polysaccharide Vaccine:					
sanofi pasteur	Menomune-A/C/Y/W-135	49281-0489-91	10 x 1	0.5 ml	$130.11
sanofi pasteur	Menomune-A/C/Y/W-135	49281-0489-01	each	0.5 ml	$130.11
Mumps Vaccine:					
Merck & Co.	Mumpsvax	00006-4584-00	10 x 0.5	0.5 ml	$ 26.54

Product Name, Company	*Brand/Product Name*	*NDC Number*	*Unit*	*Dose*	*AWP/Dose**
Rubella Vaccine:					
Merck & Co.	Meruvax II	00006-4673-00	10 x 0.5	0.5 ml	$ 22.83
Hepatitis A Vaccine (HEP-A):					
Merck & Co.	VAQTA—syringe	00006-4096-31	1.0 ml	1.0 ml	$ 77.89
Merck & Co.	VAQTA—syringe	00006-4096-06	6 x 1	1.0 ml	$ 77.87
Merck & Co.	VAQTA	00006-4841-00	1.0 ml	1.0 ml	$ 76.21
Merck & Co.	VAQTA	00006-4841-41	10 x 1	1.0 ml	$ 71.99
Merck & Co.	VAQTA Pediatric	00006-4831-41	10 x 0.5	0.5 ml	$ 36.44
GlaxoSmithKline	Havrix Ped—syringe	58160-0825-52	10 x 1	0.5 ml	$ 34.34
GlaxoSmithKline	Havrix Pediatric	58160-0825-11	10 x 1	0.5 ml	$ 34.34
GlaxoSmithKline	Havrix—syringe	58160-0826-46	5 x 1	1 ml	$ 72.68
GlaxoSmithKline	Havrix	58160-0826-11	10 x 1	1 ml	$ 72.68
Varicella Virus Vaccine:					
Merck & Co.	Varivax	00006-4826-00	each	0.5 ml	$105.29
Merck & Co.	Varivax	00006-4827-00	10 x 1	0.5 ml	$100.38
Merck & Co.	Zostavax	00006-4963-00	each	19400 pfu	$193.80
Merck & Co.	Zostavax	00006-4963-41	10 x 1	19400 pfu	$184.72
Human Papilloma Virus Vaccine:					
Merck & Co.	Gardasil	00006-4045-00	each	0.5 ml	$156.50
Merck & Co.	Gardasil	00006-4045-41	10 x 1	0.5 ml	$156.18
Merck & Co.	Gardasil—syringe	00006-4109-06	6 x 1	0.5 ml	$158.00
Merck & Co	Gardasil—syringe w/o needle	00006-4109-09	6 x 1	0.5 ml	$158.00
GlaxoSmithKline	Cervarix	58160-0830-11	10 x 1	0.5 ml	$128.75
GlaxoSmithKline	Cervarix—syringe	58160-0830-46	5 x 1	0.5 ml	$128.75

Product Name, Company	*Brand/Product Name*	*NDC Number*	*Unit*	*Dose*	*AWP/Dose**
Rotavirus Vaccine:					
Merck & Co.	Rotateq	00006-4047-41	10 x 1	2 ml	$ 83.35
GlaxoSmithKline	Rotarix	58160-0805-11	10 x 1	1.0 ml	$122.85
Influenza Virus Vaccine:					
Novartis	Fluvirin	66521-113-02	10 x 1	0.5 ml	$ 18.24
Novartis	Fluvirin	66521-113-10	10 x 1	0.5 ml	$ 14.81
Sanofi pasteur	Fluzone	49281-0011-10	10 x 1	0.5 ml	$ 15.58
Sanofi pasteur	Fluzone	49281-0011-50	10 x 1	0.5 ml	$ 15.58
Sanofi pasteur	Fluzone	49281-0388-15	10 x 1	0.5 ml	$ 14.01
Sanofi pasteur	Fluzone Pediatric	49281-0111-25	10 x 1	0.25 ml	$ 16.53
GlaxoSmithKline	Fluarix	58160-0873-46	5 x 1	0.5 ml	$ 15.75
MedImmune	Flumist	66019-0108-10	10 x 1	0.2 ml	$ 22.31
Merck & Co.	Afluria	33332-0010-01	10 x 1	0.5 ml	$ 13.05
Merck & Co.	Afluria	33332-0111-10	Multidose	0.5 ml	$ 12.15
Hepatitis B Vaccine (HEP-B):					
Merck & Co.	Recombivax HBHepatitis B vaccine (Recombinant) Dialysis Formulation	00006-4992-00	each	1.0 ml	$165.29
Merck & Co.	Recombivax HB Pediatric	00006-4981-00	10 x 0.5 ml	0.5 ml	$ 27.85
Merck & Co.	Recombivax HB	00006-4995-00	1.0 ml	1.0 ml	$ 71.64
Merck & Co.	Recombivax HB	00006-4995-41	10 x 1.0 ml	1.0 ml	$ 70.81

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Product Name, Company	*Brand/Product Name*	*NDC Number*	*Unit*	*Dose*	*AWP/Dose**
Merck & Co.	Recombivax HB syringe	00006-4094-31	1.0 ml	1.0 ml	$ 73.31
Merck & Co.	Recombivax HB syringe	00006-4094-06	6 x 1.0 ml	1.0 ml	$ 73.31
Merck & Co	Recombivax HB syringe w/o needle	00006-4094-09	6 x 1.0 ml	1.0 ml	$ 73.31
GlaxoSmithKline	Engerix-B Pediatric	58160-0820-11	10 x 1	0.5 ml	$ 25.49
GlaxoSmithKline	Engerix-B Pediatric	58160-0820-46	5 x 1	0.5 ml	$ 25.49
GlaxoSmithKline	Engerix-B Pediatric	58160-0856-35	5 x 1	0.5 ml	$ 25.49
GlaxoSmithKline	Engerix-B syringe	58160-0821-51	10 x 1	1.0 ml	$ 62.85
GlaxoSmithKline	Engerix-B syringe	58160-0821-11	10 x 1	1.0 ml	$ 62.85
Hepatitis B / HIB:					
Merck & Co.	COMVAX	00006-4898-00	10 x 0.5 ml	0.5 ml	$ 52.27
Hepatitis A & Hepatitis B Vaccine:					
GlaxoSmithKline	Twinrix	58160-0815-11	10 x 1.0	1.0 ml	$103.43
GlaxoSmithKline	Twinrix—syringe	58160-0815-46	5 x 1.0	1.0 ml	$103.43
Pneumococcal Vaccine:					
Pfizer	Prevnar 13	0005-1971-02	10 x 1	0.5 ml	$141.75
Merck & Co.	Pneumovax 23	00006-4739-00	2.5 ml	0.5 ml	$ 60.20
Merck & Co.	Pneumovax 23	00006-4943-00	10 x 1	0.5 ml	$ 67.58
Measles, Mumps, Rubella, and Varicella Vaccine					
Merck & Co.	ProQuad	00006-4999-00	10 x 0.5	0.5 ml	$160.12

Source

The provisions of this Appendix H adopted February 3, 1995, effective February 4, 1995, 25 Pa.B. 511; amended August 16, 1996, effective August 17, 1996, 26 Pa.B. 3958; amended August 10, 2001, effective August 11, 2001, 31 Pa.B. 4498; amended October 25, 2002, effective October 26, 2002, 32 Pa.B. 5352; amended March 14, 2003, effective March 15, 2003, 33 Pa.B. 1418; amended April 16, 2004, effective April 17, 2004, 34 Pa.B. 2135; amended September 16, 2005, effective September 17, 2005, 35 Pa.B. 5190; amended January 19, 2007, effective January 20, 2007, 37 Pa.B. 372; amended December 21, 2007, effective December 22, 2007, 37 Pa.B. 6851; amended February 27, 2009, effective February 28, 2009, 39 Pa.B. 1167; amended February 5, 2010, effective February 6, 2010, 40 Pa.B. 760; amended September 17, 2010, effective September 18, 2010, 40 Pa.B. 5404; amended March 4, 2011, effective March 5, 2011, 41 Pa.B. 1263; amended October 28, 2011, effective October 29, 2011, 41 Pa.B. 5821. Immediately preceding text appears at serial pages (356175) to (356181).

Cross References

This appendix cited in 31 Pa. Code § 89.807 (relating to immunizing agents, doses and AWPs).

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.)

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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

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• 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

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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

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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

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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.)

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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.

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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.

Source

The provisions of this Appendix I adopted May 10, 1996, effective May 11, 1996, 26 Pa.B. 2196; amended January 8, 1999, effective January 9, 1999, 29 Pa.B. 172. Immediately preceding text appears at serial pages (218640) and (214691) to (214698).

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