DEPARTMENT OF INSURANCE

Statutory Authority: 18 Delaware Code, Sections 314 and 3403 (18 **Del.C.** §§314 & 3403)
18 **DE Admin. Code** 1501

FINAL

ORDER

1501 Medicare Supplement Insurance Minimum Standards

After publication of proposed Regulation 1501 in the *Delaware Register of Regulations* on November 1, 2006, the public comment period on the proposed regulation remained open until January 3, 2007. Public notice of the proposed amendment to Regulation 1501 in two newspapers of general circulation was in conformity with Delaware law. Since the public notice of the proposed amendments to the regulation was not published in two newspapers of general circulation until November 30, 2006, the comment period remained open until January 3, 2007. There was one favorable comment received by the Department of Insurance from the State Council for Persons with Disabilities in response to the public notice in the *Register of Regulations* or the two newspapers of general circulation in the State of Delaware.

Summary of the Evidence and Information Submitted

Prior to the amendment effective on September 15, 2004, section 17.4.4 provided that all insurers had to make Plans A, B, C and F available in the State. The September 15, 2004 amendment contained a typographical error that resulted in the requirement that only Plan A be made available. The purpose of this amendment is to reinstate the original requirement that all insurers make Plans A, B, C and F available in the State. The State Council for Persons with Disabilities was in favor of the proposed change because of its favorable impact on Delaware consumers.

Findings of Fact

The purpose for this amendment is to reinstate the original requirement that all insurers make Plans A, B, C and F available in the State. There were no objections to the adoption of the proposed changes to the regulation. I find that the proposed change does nothing more that reinstate a long standing requirement in Delaware and makes more choices available for consumers in this State.

Decision

Based on the provisions of 18 **Del.C.** §§311 and 3403, and the record in this docket, I find that there is substantial evidence in favor of the adoption of the proposed amendment to Regulation 1501 to become effective on February 11, 2007.

Text and Citation

The text of the proposed amendments to Regulation 1501 last appeared in the *Register of Regulations* Vol. 10, Issue 5, pages 802-804, November 1, 2006.

IT IS SO ORDERED this 5th day of January, 2007

Matthew Denn
Insurance Commissioner

1501 Medicare Supplement Insurance Minimum Standards [Formerly Regulation 41]

1.0 Purpose

The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies or contracts; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

7 DE Reg. 800 (12/1/02)

2.0 Authority

This regulation is issued pursuant to the authority vested in the Commissioner under 18 **Del.C.** §§311 and 3403.

7 DE Reg. 800 (12/1/02)
8 DE Reg. 1026 (1/1/05)

3.0 Applicability and Scope

3.1 Except as otherwise specifically provided in Sections 7, 13, 14, 17 and 22, this regulation shall apply to:

3.1.1 All Medicare supplement policies delivered or issued for delivery in this State on or after the effective date of this regulation, and

3.1.2 All certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this State.

3.2 This regulation shall 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 combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

7 DE Reg. 800 (12/1/02)
8 DE Reg. 1026 (1/1/05)

4.0 Definitions

For purposes of this regulation:

4.1 **"Applicant"** means:

4.1.1 In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

4.1.2 In the case of a group Medicare supplement policy, the proposed certificateholder.

4.2 **"Bankruptcy"** means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

4.3 **"Certificate"** means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

4.4 **"Certificate Form"** means the form on which the certificate is delivered or issued for delivery by the issuer.

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

4.6 **"Creditable Coverage"**

4.6.1 **"Creditable Coverage"** means, with respect to an individual, coverage of the individual provided under any of the following:

4.6.1.1 A group health plan;

4.6.1.2 Health insurance coverage;

4.6.1.3 Part A or Part B of Title XVIII of the Social Security Act (Medicare);

4.6.1.4 Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;

4.6.1.5 Chapter 55 of Title 10 United States Code (CHAMPUS)

4.6.1.6 A medical care program of the Indian Health Service or of a tribal organization;

4.6.1.7 A State health benefits risk pool;

4.6.1.8 A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

4.6.1.9 A public health plan as defined in federal regulation; and

4.6.1.10 A health benefit plan under section 5(e) of the Pace Corps Act (22 United States Code 2504(e)).

4.6.2 **"Creditable Coverage"** shall not include one or more, or any combination of, the following:

4.6.2.1 Coverage only for accident or disability income insurance, or any combination thereof;

4.6.2.2 Coverage issued as a supplement to liability insurance;

4.6.2.3 Liability insurance, including general liability insurance and automobile liability insurance;

4.6.2.4 Workers' compensation or similar insurance;

4.6.2.5 Automobile medical payment insurance;

4.6.2.6 Credit-only insurance;

4.6.2.7 Coverage for on-site medical clinics; and

4.6.2.8 Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

4.6.3 **"Creditable Coverage"** shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

4.6.3.1 Limited scope dental or vision benefits;

4.6.3.2 Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

4.6.3.3 Such other similar, limited benefits as are specified in federal regulations.

4.6.4 "Creditable coverage: shall not include the following benefits if offered as independent, noncoordinated benefits:

4.6.3.1 Coverage only for a specified disease or illness; and

4.6.3.2 Hospital indemnity or other fixed indemnity insurance.

4.6.5 **"Creditable Coverage"** shall not include the following if it is offered as a separate policy, certificate of contract of insurance:

4.6.5.1 Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

4.6.5.2 Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and

4.6.5.3 Similar supplemental coverage provided to coverage under a group health plan.

4.7 **"Employee Welfare Benefit Plan"** means a plan, fund or program of employee benefits as defined in 29 U.S.C. section 1002 (Employee Retirement Income Security Act).

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

4.9 **"Issuer"** includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

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

4.11 **"Medicare Advantage Plan"** means a plan of coverage for health benefits under Medicare Part C as defined in [refer to definition of Medicare Advantage plan in 42 U.S.C. §1395w-28(b)(1)], and includes:

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

4.11.2 Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and

4.11.3 Medicare Advantage private fee-for-service plans.

4.12 **"Medicare Supplement Policy"** means a group or individual policy of accident and sickness insurance or a subscriber contract other than a policy issued pursuant to a contract of hospital and medical service associations or health maintenance organizations, under section 1876 of the Federal Social Security Act (42 U.S.C. section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. §1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. "Medicare supplement policy" 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 pursuant to an agreement under §1833(a)(1)(A) of the Social Security Act.

4.13 **"Policy Form"** means the form on which the policy is delivered or issued for delivery by the issuer.

4.14 **"Secretary"** means the Secretary of the United States Department of Health and Human Services.

2 DE Reg. 2055 (5/1/99)
7 DE Reg. 800 (12/1/02)
8 DE Reg. 1026 (1/1/05)

5.0 Policy Definitions and Terms

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

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

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

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

5.2 **"Benefit Period" or "Medicare Benefit Period"** shall not be defined more restrictively than as defined in the Medicare program.

5.3 **"Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility"** shall not be defined more restrictively than as defined in the Medicare program.

5.4 **"Health Care Expenses"** means, for purposes of Section 14, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

5.5 **"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.

5.6 **"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.

5.7 **"Medicare Eligible Expenses"** shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

5.8 **"Physician"** shall not be defined more restrictively than as defined in the Medicare program.

5.9 **"Sickness"** shall not be defined to be more restrictive than the following:

"Sickness means illness or disease of an insured person which first manifests itself 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.

7 DE Reg. 800 (12/1/02)
8 DE Reg. 1026 (1/1/05)

6.0 Policy Provisions

6.1 Except for permitted preexisting condition clauses as described in section 7.1.1 and section 8.1.1 of this Regulation, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

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

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

6.4 Issuance and renewal

6.4.1 Subject to sections 7.1.4, 5 and 7, and 8.1.4 and 5, 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.

6.4.2 A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

6.4.3 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:

6.4.3.1 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 and;

6.4.3.2 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.

Drafting Note: After December 31, 2005, MMA prohibits issuers of Medicare supplement policies from renewing outpatient prescription drug benefits for both pre-standardized and standardized Medicare supplement policyholders who enroll in Medicare Part D. Before May 15, 2006, these beneficiaries have two options: retain their current plan with outpatient prescription drug coverage removed and premiums adjusted appropriately; or enroll in a different policy as guaranteed for beneficiaries affected by these changes mandated by MMA and outlined in Section 12, "Guaranteed Issue for Eligible Persons." After May 15, 2006 however, these beneficiaries will only retain a right to keep their original policies, stripped of outpatient prescription drug coverage, and lose the right to guaranteed issue of the plans described in Section 12.

7 DE Reg. 800 (12/1/02)
8 DE Reg. 1026 (1/1/05)

7.0 Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to January 1, 1992

No policy or certificate may be advertised, solicited or issued for delivery in this State 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 not inconsistent with these standards.

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

7.1.1 A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall 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 six (6) months before the effective date of coverage.

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

7.1.3 A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable

Medicare deductible amount and co-payment percentage factors. Premiums may be modified to correspond with such changes.

7.1.4 A “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” Medicare supplement policy shall not:

7.1.4.1 Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

7.1.4.2 Be cancelled or nonrenewed by the insurer solely on the grounds of deterioration of health.

7.1.5 Except as authorized by the Commissioner of this state, an issuer Shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph 7.1.5.4, the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:

7.1.5.1 An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

7.1.5.2 An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in section 8.2 of this regulation.

7.1.5.3 If membership in a group is terminated, the issuer shall:

7.1.5.3.1 Offer the certificateholder the conversion opportunities as are described in section 7.1.5; or

7.1.5.3.2 At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

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

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

7.1.7 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 modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

7.2 Minimum Benefit Standards.

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

7.2.2 Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

7.2.3 Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare’s lifetime hospital inpatient reserve days;

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

7.2.5 Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

7.2.6 Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$100];

7.2.7 Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

7.2.8 Cancer Screening every other year for both men and women as recommended by the U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, except that nothing in this section shall contravene section 7.1 of this regulation.

7.2.9 Annual influenza immunizations.

7 DE Reg. 800 (12/1/02)
8 DE Reg. 1026 (1/1/05)

8.0 Benefit Standards for Policies or Certificates Issued or delivered on or after January 1, 1992.

The following standards are applicable to all Medicare supplement policies of certificates delivered or issued for delivery in this State on or after January 1, 1992. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this State as a Medicare supplement policy or certificate unless it complies with these benefit standards.

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

8.1.1 A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (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 six (6) months before the effective date of coverage.

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

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

8.1.4 No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverages of the insured, other than the nonpayment of premium.

8.1.5. Each Medicare supplement policy shall be guaranteed renewable and

8.1.5.1 The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

8.1.5.2 The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or materials misrepresentation.

8.1.5.3 If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under section 8.1.5.5, the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificate holder):

8.1.5.3.1 Provides for continuation of the benefits contained in the group policy; or

8.1.5.3.2 Provides for such benefits that otherwise meet the requirements of this subsection.

8.1.5.4 If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

8.1.5.4.1 Offer the certificateholder the conversion opportunity described in section 8.1.5.3; or

8.1.5.4.2 At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

8.1.5.5 If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new

policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

8.1.5.6 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 modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

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

8.1.7 Policy or Certificate Suspension

8.1.7.1 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 twenty-four (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, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance. Upon receipt of timely notice, the issuer shall return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

8.1.7.2 If such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of such entitlement, if the policyholder or certificate holder provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

8.1.7.3 Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan (as defined in section 1862(b)(1)(A)(v) of the Social Security Act.). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 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.

8.1.7.4 Reinstitution of coverages as described in sections 8.1.7.2 and 8.1.7.3:

8.1.7.4.1 Shall not provide for any waiting period with respect to treatment of preexisting conditions;

8.1.7.4.2 Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of such 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; and

8.1.7.4.3 Shall provide for classification of premiums on terms as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

8.2 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 may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic “core” package, but not in lieu of it:

8.2.1 Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

8.2.2 Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

8.2.3 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 must accept the issuer's payment as payment in full and may not bill the insured for any balance;

8.2.4 Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packaged red blood cells as defined under federal regulations) unless replaced in accordance with federal regulations.

8.2.5 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.

8.3 Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by section 9 of this Regulation.

8.3.1 Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

8.3.2 Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

8.3.3 Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

8.3.4 Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

8.3.5 One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

8.3.6 Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

8.3.7 Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent no coverage by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

8.3.8 Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

8.3.9 Preventive Medical Care Benefit: Reimbursement shall be for the actual charges up to one hundred (100) percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare. Coverage shall be provided for the following preventive health services not covered by Medicare:

8.3.9.1 An annual clinical preventive medical history and physical examination that may include tests and services from subsection (b) and patient education to address preventive health care measures.

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

8.3.10 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.

8.3.10.1 For purposes of this benefit, the following definitions shall apply:

8.3.10.1.1 "**Activities of Daily Living**" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

8.3.10.1.2 "**Care Provider**" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

8.3.10.1.3 "**Home**" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

8.3.10.1.4 "**At-home Recovery Visit**" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is one visit.

8.3.10.2 Coverage Requirements and Limitations

8.3.10.2.1 At-home recovery services provided must be primarily services which assist in activities of daily living.

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

8.3.10.3 Coverage is limited to:

8.3.10.3.1 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 shall not exceed the number of Medicare approved home health care visits under a Medicare approved Home Care Plan of Treatment.

8.3.10.3.2 The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit.

8.3.10.3.3 One thousand six hundred dollars ($1,600) per calendar year.

8.3.10.3.4 Seven (7) visits in any one week.

8.3.10.3.5 Care furnished on a visiting basis in the insured's home.

8.3.10.3.6 Services provided by a care provider as defined in this section.

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

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

8.3.10.4 Coverage is excluded for:

8.3.10.4.1 Home care visits paid for Medicare or other government programs; an

8.3.10.4.2 Care provided by family members, unpaid volunteers or providers who are not care providers.

8.4 Standards for Plans K and L

8.4.1 Standardized Medicare supplement benefit plan "K" shall consist of the following:

8.4.1.1 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;

8.4.1.2 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;

8.4.1.3 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;

8.4.1.4 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 section 8.4.1.10;

8.4.1.5 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 post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in section 8.4.1.10;

8.4.1.6 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 section 8.4.1.10;

8.4.1.7 Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in section 8.4.1.10;

8.4.1.8 Except for coverage provided in subparagraph (i) below, 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 section 8.4.1.10;

8.4.1.9 Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

8.4.1.10 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 $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

8.4.2 Standardized Medicare supplement benefit plan "L" shall consist of the following:

8.4.2.1 The benefits described in sections 8.4.1.1, 2, 3, and 9;

8.4.2.2 The benefit described in sections 8.1.4.4, 5, 6, 7, and 8, but substituting 75% for 50%; and

8.4.2.3 The benefit described in Paragraph 8.4.1.10, but substituting $2000 for $4000.

7 DE Reg. 800 (12/1/02)
8 DE Reg. 1026 (1/1/05)

9.0 Standard Medicare Supplement Benefit Plans

9.1 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 sections 8.2 of this regulation.

9.2 No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in section 9.7 and in section 10 of this regulation.

9.3 Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans “A” through “L” listed in this subsection and conform to the definitions in section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in sections 8.2 and 8.3, or 8.4 and list the benefits in the order shown in this subsection. For purposes of this section, “structure, language and format” means style, arrangement and overall content of a benefit.

9.4 An issuer may use, in addition to the benefit plan designations required in section 9.3, other designations to the extent permitted by law.

9.5 Make-up of Benefit Plans:

9.5.1 Standardized Medicare supplement benefit plan “A” shall be limited to the basic (“core”) benefits common to all benefit plans, as defined in section 8.2 of this regulation.

9.5.2 Standardized Medicare supplement benefit plan “B” shall include only the following: the core benefit as defined in section 8.2 of this regulation, plus the Medicare Part A deductible as defined in section 8.3.1.

9.5.3 Standardized Medicare supplement benefit plan “C” shall include only the following: The core benefit as defined in section 8.2 of this regulation, 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 sections 8.3.1, 2, 3 and 8 respectively.

9.5.4 Standardized Medicare supplement benefit plan “D” shall include only the following: the core benefit as defined in section 8.2 of this regulation, 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 sections 8.3.1, 2, 8 and 10 respectively.

9.5.5 Standardized Medicare supplement benefit plan “E” shall include only the following: the core benefit as defined in section 8.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical Care as defined in sections 8.3.1, 2, 8 and 9 respectively.

9.5.6 Standardized Medicare supplement benefit plan “F” shall include only the following: the core benefit as described in section 8.2 of this regulation plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred (100%) of the Medicare Part B excess charges, and the medically necessary emergency care in a foreign country as defined in sections 8.3.1, 2, 3, 5 and 8 respectively.

9.5.7 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 section 8.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in sections 8.3.1, 2, 3, 5 and 8 respectively. The annual high deductible plan “F” deductible shall consist of out-of-pocket expenses, other than premiums, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan “F” deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

9.5.8 Standardized Medicare supplement benefit plan “G” shall include only the following: The core benefit as defined in section 8.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in sections 8.3.1, 2, 4, 8 and 10 respectively.

9.5.9 Standardized Medicare supplement benefit plan “H” shall include only the following: the core benefit as defined in section 8.2 of this regulation, 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 sections 8.3.1, 2, 6 and 8 respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

9.5.10 Standardized Medicare supplement benefit plan “I” shall consist of only the following: the core benefit as defined in section 8.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in sections 8.3.1, 2, 5, 6, 8 and 10 respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

9.5.11 Standardized Medicare supplement benefit plan “J” shall consist of only the following: the core benefit as defined in section 8.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in sections 8.3.1, 2, 3, 5, 7, 8, 9 and 10 respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

9.5.12 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 section 8.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in sections 8.3.1, 2, 3, 5, 7, 8, 9, and 10 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 high deductible plan “J” deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period

ending with August of the preceding year, and rounded to the nearest multiple of $10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

9.6 Make-up of two Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA);

9.6.1 Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in Section 8.4.1.

9.6.2 Standardized Medicare supplement benefit plan "L" shall consist of only those benefits described in Section 8.4.2.

9.7 New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. 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 shall not include an outpatient prescription drug benefit.

7 DE Reg. 800 (12/1/02)
8 DE Reg. 1026 (1/1/05)

10.0 Medicare Select Policies and Certificates:

10.1 This section shall apply to Medicare Select policies and certificates, as defined in this section. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

10.2 For the purposes of this section:

10.2.1 **"Complaint"** means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

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

10.2.3 **"Medicare Select Issuer"** means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

10.2.4 **"Medicare Select Policy"** or **"Medicare Select Certificate"** mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

10.2.5 **"Network Provider"** means 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.

10.2.6 **"Restricted Network Provision"** means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

10.2.7 **"Service Area"** means the geographic area approved by the Commissioner within which an issued is authorized to offer a Medicare Select policy.

10.3 The Commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to his section and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the Commissioner finds that the issuer has satisfied all of the requirements of this regulation.

10.4 A Medicare Select issue shall not issue a Medicare Select policy or certificate in this State until its plan of operation has been approved by the Commissioner.

10.5 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:

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

10.5.1.1 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 usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

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

10.5.1.2.1 To deliver adequately all services that are subject to a restricted network provision; or

10.5.1.2.2 To make appropriate referrals.

10.5.1.3 There are written agreements with network providers describing specific responsibilities.

10.5.1.4 Emergency care is available twenty-four (24) hours per day and seven (7) days per week.

10.5.1.5 In the case of covered services that are subject to a restricted network 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 paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

10.5.2 A statement or may providing a clear description of the service area.

10.5.3 A description of the grievance procedure to be utilized.

10.5.4 A description of the quality assurance program, including:

10.5.4.1 The formal organizational structure;

10.5.4.2 The written criteria for selection, retention and removal of network providers; and

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

10.5.5 A list and description, by specialty, of the network providers.

10.5.6 Copies of the written information proposed to be used by the issuer to comply with section 10.9.

10.5.7 Any other information requested by the Commissioner.

10.6 A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers with the Commissioner prior to implementing such changes. Such changes shall be considered approved by the Commissioner after thirty (30) days unless specifically disapproved. An updated list of network providers shall be filed with the Commissioner at least quarterly.

10.7 A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

10.7.1 The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

10.7.2 .It is not reasonable to obtain such services through a network provider.

10.8 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.

10.9 A Medicare Select issuer shall make a 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:

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

10.9.1.1 Other Medicare supplement policies or certificates offered by the issuer; and

10.9.1.2 Other Medicare Select policies or certificates.

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

10.9.3 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.

10.9.4 A description of coverage for emergency and urgently needed care and other out of service area coverage.

10.9.5 A description of limitations on referrals to restricted network providers and to other providers.

10.9.6 A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

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

10.10 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 pursuant to section 10.9 of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

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

10.11.1 The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

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

10.11.3 Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

10.11.4 If a grievance is found to be valid, corrective action shall be taken promptly

10.11.5 All concerned parties shall be notified about the results of a grievance.

10.11.6 The issuer shall report no later than each March 31st 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 such grievances.

10.12 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.

10.13 Opportunity to Purchase Medicare Supplement Policy

10.13.1 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 six (6) months.

10.13.2 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.

10.14 Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be re-authorized under law or its substantial amendment.

10.14.1 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 issued which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

10.14.2 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 coverages for Part B excess charges.

10.15 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.

7 DE Reg. 800 (12/1/02)
8 DE Reg. 1026 (1/1/05)

11.0 Open Enrollment

11.1 An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subsection without regard to age or eligibility for a group Medicare supplement plan. At a minimum, issuers shall make available, in accordance with this section, Medicare supplement policies or certificates having benefit packages classified as Plans A, B, C and F.

11.2 Exclusions and Preexisting Conditions

11.2.1 If an applicant qualifies under section 11.1 and submits an application during the time period referenced in section 11.1 and, as of the date of the application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

11.2.2 If the applicant qualifies under section 11.1 and submits an application during the time period referenced in section 11.1 1 and, as of the date of application, has had a continuous period of creditable coverage that is less than six 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 Secretary shall specify the manner of the reduction under this subsection.

11.3 Except as provided in section 11.2 and sections 12 and 23.1, section 11.1 shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

7 DE Reg. 800 (12/1/02)
8 DE Reg. 1026 (1/1/05)

12.0 Guaranteed Issue for Eligible Persons

12.1 Guaranteed Issue

12.1.1 Eligible persons are those individuals described in section 12.2, who seek to enroll under the policy during the period specified in section 12.3, and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

12.1.2 With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in section 12.5 that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

12.2 An eligible person is an individual described in any of the following paragraphs:

12.2.1 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 some or all such supplemental 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 some or all health benefits to the individual because the individual leaves the plan.

12.2.2 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 and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

12.2.2.1 The certification of the organization or plan under this part has been terminated; or

12.2.2.2 The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

12.2.2.3 The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

12.2.2.4 The individual demonstrates, in accordance with guidelines established by the Secretary, that

12.2.2.4.1 The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

12.2.2.4.2 The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

12.2.2.5 The individual meets such other exceptional conditions as the Secretary may provide.

12.2.3 The individual is enrolled with:

12.2.3.1 An eligible organization under a contract under section 1876 of the Social Security Act (Medicare Cost);

12.2.3.2 A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

12.2.3.3 An organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

12.2.3.4 An organization under a Medicare Select policy; and

12.2.3.5 The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under section 12.2.2.

12.2.4 The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

12.2.4.1 Of the insolvency of the issuer or bankruptcy of the non-issuer organization or of other involuntary termination of coverage or enrollment under the policy;

12.2.4.2 The issuer of the policy substantially violated a material provision of the policy; or

12.2.4.3 The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

12.2.5 Subsequent first time enrollment with Medicare Advantage

12.2.5.1 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), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a Medicare Select policy; and

12.2.5.2 The subsequent enrollment under subparagraph (a) is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

12.2.6 The individual, upon first becoming eligible for benefits under Part A of Medicare at age 65, 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 by not later than twelve (12) months after the effective date of enrollment.

12.2.7 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 section 12.5.4.

12.3 Guaranteed Issue Time Periods

12.3.1 In case of an individual described in section 12.2.1, the guaranteed issue period begins on the later of:

12.3.1.1 the date the individual receives a notice of termination or cessation of all supplemental health benefits (or if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or

12.3.1.2 the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

12.3.2 In the case of an individual described in sections 12.2.2, 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 sixty-three (63) days after the date the applicable coverage is terminated;

12.3.3 In the case of an individual described in section 12.2.4.1, the guaranteed issue period begins on the earlier of:

12.3.3.1 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, and

12.3.3.2 the date that the applicable coverage is terminated and ends on the date that is sixty-three (63) days after the date the coverage is terminated;

12.3.4 In the case of an individual described in sections 12.2.2, 12.2.4.2, 12.2.4.3, 12.2.5 or 12.2.6 who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date:

12.3.5 In the case of an individual described in section 12.2.7, 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 sixty-day period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

12.3.6 In the case of an individual described in 12.2 but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.

12.4 Extended Medigap Access for Interrupted Trial Periods

12.4.1 In the case of an individual described in 12.2.5. (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in 12.2.5.1 is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in section 12.2.5.

12.4.2 In the case of an individual described in section 12.2.6 (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in section 12.2.6 is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in section 12.2.6; and

12.4.3 For purposes of sections 12.2.5 and 6, no enrollment of an individual with an organization or provider described in section 12.2.5.1, or with a plan or in a program described in section 12.2.6, may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

12.5 Products to Which Eligible Persons are Entitled.

The Medicare supplement policy to which eligible persons are entitled under:

12.5.1 Section 12.2.1, 2, 3, and 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 any issuer.

12.5.2

12.5.2.1 Subject to section 12.5.2.2, Section 12.2.5 is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in section 12.5.1.

12.5.2.2 After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this subsection is:

12.5.2.2.1 The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

12.5.2.2.2 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;

12.5.3 Section 12.2.6 shall include any Medicare supplement policy offered by any issuer.

12.5.4 Section 12.2.7 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.

12.6 Notification Provisions

12.6.1 At the time of an event described in section 12.2 because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under section 12.1. Such notice shall be communicated contemporaneously with the notification of termination.

12.6.2 At the time of an event described in section 12.2 because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under section 12.1. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

7 DE Reg. 800 (12/1/02)
8 DE Reg. 465 (9/01/04)
8 DE Reg. 1026 (1/1/05)

13.0 Standards for Claims Payment

13.1 An issuer shall comply with section 1882(c)(3) of the Social Security Act (as enacted by section 408 1(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA), Pub. L. No. 100—203) by:

13.1.1 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 any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

13.1.2 Notifying the participating physician or supplier and the beneficiary of the payment determination;

13.1.3 Paying the participating physician or supplier directly;

13.1.4 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;

13.1.5 Paying user fees for claim notices that are transmitted electronically or otherwise; and

13.1.6 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.

13.2 Compliance with the requirements set forth in Subsection A above shall be certified on the Medicare supplement insurance experience reporting form.

7 DE Reg. 800 (12/1/02)

14.0 Loss Ratio Standards and Refund or Credit of Premium

14.1 Loss Ratio Standards

14.1.1 A Medicare Supplement policy form or certificate form shall 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 provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

14.1.1.1 At least 75 percent of the aggregate amount of premiums earned in the case of group policies, or

14.1.1.2 At least 65 percent of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices~~.~~:

14.1.2 Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

14.1.2.1 Home office and overhead costs;
14.1.2.2 Advertising costs;
14.1.2.3 Commissions and other acquisition costs;
14.1.2.4 Taxes;
14.1.2.5 Capital costs;
14.1.2.6 Administrative costs; and
14.1.2.7 Claims processing costs.

14.1.3 All filings of rates and rating schedules shall demonstrate that Expected claims in relation to premiums comply with the requirements of 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.

14.1.4 For purposes of applying sections 14.1.1 and 15.3.3 only, policies Issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

14.2 Refund or Credit Calculation

14.2.1 An issuer shall collect and file with the Commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

14.2.2 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.

14.2.3 For the purposes of this section, policies or certificates issued prior to January 1, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after the (effective date of this amendment). The first such report shall be due by May 31, 1998.

14.2.4 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. The 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 in no event shall it 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

14.3 Annual Filing of Premium Rates

An issuer of Medicare supplement policies and certificates issued before or after the effective date of January 1, 1992 in this State 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. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or Medicare supplement policies or certificates in this State shall file with the Commissioner, in accordance with the applicable filing procedures of this State:

14.3.1 Premium Adjustments

14.3.1.1 Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or contracts. The supporting documents as necessary to justify the adjustment shall accompany the filing.

14.3.1.2 An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under the policy or certificate to conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement insurance policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein should be made with respect to a policy at any time other than upon its renewal date or anniversary date.

14.3.1.3 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.

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

14.4 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 or after the effective date of this Regulation 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 such reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the Commissioner.

7 DE Reg. 800 (12/1/02)
8 DE Reg. 1026 (1/1/05)

15.0 Filing and Approval of Policies and Certificates and Premium Rates

15.1 An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this State 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.

15.2 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 only with the commissioner in the state in which the policy or certificate was issued.

15.3 An issuer shall 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.

15.4 Filing

15.4.1 Except as provided in section 5.4.2, an insurer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

15.4.2 An issuer may offer, with the approval of the Commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases.

15.4.2.1 The inclusion of new or innovative benefits;

15.4.2.2 The addition of either direct response or agent marketing methods;

15.4.2.3 The addition of either guaranteed issue or underwritten coverage;

15.4.2.4 The offering of coverage to individuals eligible for Medicare by reason of disability.

15.4.3 For the purposes of this action, a “type” means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

15.5 Availability of Policy Forms

15.5.1 Except as provided in section 15.4.1.1, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this Regulation that has been

approved by the Commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months.

15.5.1.1 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 shall no longer offer for sale the policy form or certificate form in this State.

15.5.1.2 An issuer that discontinues the availability of a policy form or certificate form pursuant to section 15.5.1.1 shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the Commissioner of the discontinuance. The period of discontinuance may be reduced if the Commissioner determined that a shorter period is appropriate.

15.5.2 The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

15.5.3 A change in the rating structure or methodology shall be considered a discontinuance under section 15.5.1 unless the issuer complies with the following requirements:

15.5.3.1 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.

15.5.3.2 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.

15.6 Combination of Experience

15.6.1 Except as provided in section 15.6.2, 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 section 14 hereof.

15.6.2 Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refunds or credit calculation.

7 DE Reg. 800 (12/1/02)
8 DE Reg. 1026 (1/1/05)

16.0 Permitted Compensation Arrangements

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

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

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

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

7 DE Reg. 800 (12/1/02)

17.0 Required Disclosure Provisions

17.1 General Rules.

17.1.1 Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision must be consistent with the type of contract issued. Such 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.

17.1.2 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, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of the policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where 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.

17.1.3 Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary” or words of similar import.

17.1.4 If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as “Preexisting Condition Limitations.”

17.1.5 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 shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

17.1.6 Buyer’s Guide

17.1.6.1 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(s) eligible for Medicare shall provide to those applicants a “Guide to Health Insurance for People with Medicare” in the form developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services (CMS) and in a type size no smaller than 12 point type. Delivery of the Buyer’s Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the Buyer’s Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Buyer’s Guide shall be obtained by the issuer. Direct response issuers shall deliver the Buyer’s Guide to the applicant upon request but not later than at the time the policy is delivered.

17.1.6.2 For purposes of this section, “form” mans the language, format, type size, type proportional spacing, bold character, and line spacing.

17.2 Notice Requirements.

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

17.2.1.1 Include a description of revisions to the Medicare Program Ad a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and

17.2.1.2 Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

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

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

17.3 MMA Notice Requirements.

Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

17.4 Outline of Coverage Requirements for Medicare Supplement Policies.

17.4.1 Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant; and

17.4.2 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 such policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name:

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

17.4.3 The outline of coverage provided to applicants pursuant to 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 prescribed below in no less than twelve (12) point type. All plans A through L shall be shown on the cover page, and the plan(s) that are offered by this 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.

17.4.4 Every issuer or company must make Plans A, B. and F available to all eligible persons. The following items shall be included in the outline of coverage in the order prescribed below.

[COMPANY NAME]
Outline of Medicare Supplement Coverage-Cover Page: 1 of 2 (USE DOUBLE-SIDED FORM)
Benefit Plans _____[insert letters of plans being offered

Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans. Theise charts shows the benefits included in each of the standard Medicare supplement plans. Every company must make available Plans "A, B, C and F." Some plans may not be available in your state.

See Outlines of Coverage sections for details about ALL plans

Basic Benefits for Plans A - J: Included in All Plans
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or, in the case of hospital outpatient department services under a prospective payment system, applicable copayments. for hospital outpatient services.
Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Facility Co-Iinsurance	Skilled Nursing Facility Co-Iinsurance	Skilled Nursing Facility Co-Iinsurance	Skilled Nursing Facility Co-Iinsurance		Skilled Nursing Facility Co-Iinsurance	Skilled Nursing Facility Co-Iinsurance	Skilled Nursing Facility Co-Iinsurance	Skilled Nursing Facility Co-Iinsurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
								Basic Drugs ($1250 Limit)	Basic Drugs ($1250 Limit)	Extended Drugs ($3000 Limit)	
				Preventive Care NOT covered by Medicare						Preventive Care NOT covered by Medicare	

* Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year [$1690] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does not include, in plan J the plan's separate prescription drug deductible or, in plans F and J, the plan's foreign travel emergency deductible.

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page 2

Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	$[4000] Out of Pocket Annual Limit***	$[2000] Out of Pocket Annual Limit***

** Plans K and L provide for different cost-sharing for items and services than Plans A - J.
Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

8 DE Reg. 1026 (1/1/05)

***The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

PREMIUM INFORMATION [Boldface Type]

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

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

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

RIGHT TO RETURN POLICY [Boldface Type]

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

POLICY REPLACEMENT [Boldface Type]

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

NOTICE [Boldface Type]

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

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

[for direct response:]
[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult 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 below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 9D of this regulation.]

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$0	$[876](Part A deductible)
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	$0	Up to $[109.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

8 DE Reg. 1026 (1/1/05)

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

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

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

PARTS A & B

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

8 DE Reg. 1026 (1/1/05)

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876](Part A deductible)	$0
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	$0	Up to $[109.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

8 DE Reg. 1026 (1/1/05)

PLAN B
MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

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

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

PARTS A & B

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

8 DE Reg. 1026 (1/1/05)

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876](Part A deductible)	$0
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

8 DE Reg. 1026 (1/1/05)

PLAN C
MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

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

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

PARTS A & B

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

8 DE Reg. 1026 (1/1/05)

OTHER BENEFITS-NOT COVERED BY MEDICARE

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

8 DE Reg. 1026 (1/1/05)

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day $0	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

** **NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in

the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

8 DE Reg. 1026 (1/1/05)

PLAN D
MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

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

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

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PLAN D
PARTS A & B

OTHER BENEFITS-NOT COVERED BY MEDICARE

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days			
61st thru 90th day	All but $[876]	$[876] (Part A deductible)	$0
91st day and after:	All but $[219] a day	$[219] a day	$0
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

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PLAN E
MEDICARE (PART B)-MEDICAL SERVICES-PER BENEFIT PERIOD

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

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

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PARTS A & B

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

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PLAN E
OTHER BENEFITS-NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

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

8 DE Reg. 1026 (1/1/05)

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

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

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$1690] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	[AFTER YOU PAY **$[1690] DEDUCTIBLE,**] PLAN PAYS**	**[IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY**
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
While using 60 Lifetime reserve days	All but $[438] a day	$[438] a day	$0
Once lifetime reserve days Are used:	$0	100% of Medicare eligible expenses	$0***
Additional 365 days	$0	$0	All costs
Beyond the additional 365 days			
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

8 DE Reg. 1026 (1/1/05)

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

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

******This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$1690] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician's Services, inpatient and Outpatient medical and Surgical services and Supplies, physical and Speech therapy, Diagnostic tests, Durable medical Equipment, First $[100] of Medicare Approved amounts* Remainder of Medicare Approved amounts	$0 Generally 80%	$[100] (Part B deductible) Generally 20%	$0 $0
Part B excess charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $[100] of Medicare Approved amounts* Remainder of Medicare Approved amounts	$0 $0 80%	All costs $[100] (Part B deductible) 20%	$0 $0 $0
CLINICAL LABORATORY SERVICES—-TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F
PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[1690] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[1690] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First $[100] of Medicare approved Amounts* Remainder of Medicare approved Amounts	100% $0 80%	$0 $[100] (Part B deductible) 20%	$0 $0 $0

8 DE Reg. 1026 (1/1/05)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[1690] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[1690] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

8 DE Reg. 1026 (1/1/05)

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

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
** **NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G
MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

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

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

8 DE Reg. 1026 (1/1/05)

PLAN G
PARTS A & B

OTHER BENEFITS-NOT COVERED BY MEDICARE

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

8 DE Reg. 1026 (1/1/05)

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

8 DE Reg. 1026 (1/1/05)

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

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

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

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PARTS A & B

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

8 DE Reg. 1026 (1/1/05)

PLAN H
OTHER BENEFITS—NOT COVERED BY MEDICARE

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

8 DE Reg. 1026 (1/1/05)

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days			
61st thru 90th day	All but $[876]	$[876] (Part A deductible)	$0
91st day and after:	All but $[219] a day	$[219] a day	$0
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

8 DE Reg. 1026 (1/1/05)

PLAN I

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

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

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

8 DE Reg. 1026 (1/1/05)

PLAN I
PARTS A & B

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

8 DE Reg. 1026 (1/1/05)

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

8 DE Reg. 1026 (1/1/05)

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

** This high deductible plan pays the same benefits as Plan J after one has paid a calendar year [$1690] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate outpatient prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[876] (Part A deductible)	$0
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[109.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

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

8 DE Reg. 1026 (1/1/05)

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

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

**This high deductible plan pays the same benefits as Plan J after one has paid a calendar year [$1690] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 Generally 80%	$[100] (Part B deductible) Generally 20%	$0 $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 $0 80%	All Costs $[100] (Part B deductible) 20%	$0 $0 $0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

8 DE Reg. 1026 (1/1/05)

PLAN J or HIGH DEDUCTIBLE PLAN J
PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[1690] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[1690] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First $[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $[100] (Part B deductible) 20%	$0 $0 $0
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan —Benefit for each visit —Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit) —Calendar year maximum	$0 $0 $0	Actual charges to $40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week $1,600	Balance

8 DE Reg. 1026 (1/1/05)

PLAN J or HIGH DEDUCTIBLE PLAN J
PARTS A & B
OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds () in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[876]	$[438](50% of Part A deductible)	$[438](50% of Part A deductible)?
61st thru 90th day	All but $[219] a day	$[219] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			$0***
—Additional 365 days	$0	100% of Medicare eligible expenses	
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[54.75] a day	Up to $[54.75] a day ?
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%?
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments?

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[100] of Medicare Approved Amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	 $0 Generally 75% or more of Medicare approved amounts Generally 80%	 $0 Remainder of Medicare approved amounts Generally 10%	 $[100] (Part B deductible)**** ? All costs above Medicare approved amounts Generally 10% ?
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$4000])*
BLOOD First 3 pints Next $[100] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	 $0 $0 Generally 80%	 50% $0 Generally 10%	 50%? $[100] (Part B deductible)**** ? Generally 10% ?
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[100] of Medicare Approved Amounts*****	$0	$0	$[100] (Part B deductible) ?
Remainder of Medicare Approved Amounts	80%	10%	10%?

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

8 DE Reg. 1026 (1/1/05)

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[2000] each calendar year. The amounts that count toward your annual limit are noted with diamonds () in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $[876]	$[657] (75% of Part A deductible)	$[219] (25% of Part A deductible)?
61st thru 90th day 91st day and after:	All but $[219] a day	$[219] a day	$0
—While using 60 lifetime reserve days	All but $[438] a day	$[438] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[109.50] a day	Up to $[82.13] a day	Up to $[27.37] a day?
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	75%	25%?
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments ?

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physi-cian's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare Approved Amounts****	$0	$0	$[100] (Part B deductible)**** ?
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ?
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$2000])*
BLOOD			
First 3 pints	$0	75%	25%?
Next $[100] of Medicare Approved Amounts****	$0	$0	$[100] (Part B deductible) ?
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%?
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

8 DE Reg. 1026 (1/1/05)

PLAN L
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[100] of Medicare Approved Amounts*****	$0	$0	$[100] (Part B deductible) ?
Remainder of Medicare Approved Amounts	80%	15%	5% ?

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

8 DE Reg. 1026 (1/1/05)

[**Drafting Note**: The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate.]

17.5 Notice Regarding Policies or Certificates Which are Not Medicare Supplement Policies.

17.5.1 Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy, or a policy issued pursuant to a contract under section 1876 of the Federal Social Security Act (42 U.S.C. § 1395 et seq.), disability income policy; basic, catastrophic, or major medical expense policy; single premium nonrenewable policy or other policy identified in section 3.2 of this regulation, issued for delivery in this State to persons eligible for Medicare by reason of age shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language:

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

17.5.2 Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in section 17.5.1 shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

8 DE Reg. 1026 (1/1/05)

18.0 Requirements for Application Forms and Replacement Coverage

18.1 Application forms shall include the following questions designed to elicit information as to whether, as of the date of the 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 or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

[Statements]

- (1)You do not need more than one Medicare supplement policy.
- (2)If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- (3)You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- (4)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 that 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 the suspension.
- (5)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 cover-

age 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 the suspension.

- (6)Counseling services are 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).

[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,

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

Yes____ No____

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

Yes____ No____

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

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

[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.]

Yes____ No____

If yes,

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

Yes____ No____

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

Yes____ No____

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 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 __/__/__

(b) 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____

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

Yes____ No____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes____ No____

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

Yes____ No____

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

_____

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

Yes____ No____

(5) 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 other policy?
START __/__/__ END __/__/__
(If you are still covered under the other policy, leave "END" blank.)

18.2 Agents shall list any other health policies they have sold to the applicant.

18.2.1 List policies sold which are still in force.

18.2.2 List policies sold in the past five (5) years which are no longer in force.

18.3 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.

18.4 Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of accident and sickness coverage. One copy of such notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the insurer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of accident and sickness coverage.

18.5 The notice required by section 18.4 for an issuer shall be provided in substantially the following form in no less than twelve (12) point type.

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE
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 insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of 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, AGENT, BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement 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 premiums.

_____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 for Direct Mailers.]

_____Other (please specify) _____

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing 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.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting period, elimination periods or probationary periods.

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

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

(Signature of Agent, Broker or Other Representative)

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

(Applicant's Signature)
(Date)

*Signature not required for direct response sales.

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

8 DE Reg. 1026 (1/1/05)

19.0 Filing Requirements for Advertising

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

20.0 Standards for Marketing

20.1 An issuer directly or through its producers, shall:

20.1.1 Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

20.1.2 Establish marketing procedures to assure excessive insurance is not sold or issued.

20.1.3 Display prominently by type 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."

20.1.4 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 any such insurance.

20.1.5 Establish auditable procedures for verifying compliance with this section 20.1.

20.2 In addition to the practices prohibited in 18 **Del.C.** Ch. 23, the following acts and practices are prohibited:

20.2.1 Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of including, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

20.2.2 High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

20.2.3 Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

20.3 The terms “Medicare Supplement,” “Medigap,” “Medicare Wraparound” and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

21.0 Appropriateness of Recommended Purchase and Excessive Insurance

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

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

21.3 An issuer shall 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.

8 DE Reg. 1026 (1/1/05)

22.0 Reporting of Multiple Policies

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

22.1.1 Policy and certificate number; and

22.1.2 Date of issuance.

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

23.0 Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates

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

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

24.0 Separability

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

25.0 Effective Date

This Regulation, as amended, shall become effective on February 1, 2005. Insurers are permitted to continue using current forms, or to make changes to current forms if offering Plan K or L, as appropriate through 2005. Insurers may offer any authorized plan upon approval by the Commissioner.

8 DE Reg. 1026 (1/1/05)

10 DE Reg. 1307 (02/01/07) (Final)