Subchapter T. Minimum Standards for Medicare Supplement Policies
28 TAC §§3.3303, 3.3306, 3.3308, 3.3319, 3.3322 and 3.3326

1. INTRODUCTION. The Commissioner of Insurance adopts amendments to §§3.3303, 3.3306, 3.3308, 3.3319, 3.3322 and new §3.3326, concerning minimum standards for Medicare supplement policies issued or issued for delivery in this state. The amendments to §3.3306 and §3.3308 are adopted with changes to the proposed text published in the April 17, 2009, issue of the *Texas Register* (34 TexReg 2432). New §3.3326 is adopted with one minor change to correct a typographical error. The amendments to §§3.3303, 3.3319, and 3.3322 are adopted without changes.

2. REASONED JUSTIFICATION. The amendments and new section are necessary to incorporate the latest revisions to the National Association of Insurance Commissioners (NAIC) model rules concerning Medicare supplement insurance into the Department's existing Medicare supplement insurance rules. The revisions to the NAIC model rules were promulgated by the NAIC pursuant to the Medicare Improvements for Patients and Providers Act of 2008, Public Law 110 – 275 (MIPPA), which amends 42 U.S.C. §1395ss to overhaul the Medicare supplement plans and benefits, and pursuant to the Genetic Information Nondiscrimination Act of 2008, Public Law 110 – 233 (GINA), which amends 42 U.S.C. §1395ss to limit use of genetic testing and genetic information. The Insurance Code §1652.005 requires the Commissioner to adopt reasonable rules necessary and proper to carry out Chapter 1652 (which regulates Medicare supplement benefit plans), including rules adopted in accordance with federal law relating to the regulation of Medicare supplement benefit plan coverage that are necessary for the

State of Texas to retain certification as a state with an approved regulatory program for Medicare supplement insurance in compliance with 42 U.S.C. §1395ss. The Insurance Code §1652.051 additonally requires the Commissioner to adopt rules to establish specific standards for provision in Medicare supplement benefit paln s and standards for facilitating comparisons of different Medicare supplement benefit plans. These standards must include requirements that are at least equal to those required by federal law, rules, regulations, and standards. Section 104(a)(1) of MIPPA directs the NAIC to provide for implementation of changes made to 42 U.S.C. §1395ss by both MIPPA and GINA by amending the NAIC model rules relating to Medicare supplement insurance. Section 104(a)(2) of MIPPA further directs each State to conform its regulatory program to the revised NAIC model law and regulations within 1 year from the date the National Association of Insurance Commissioners adopts the revised NAIC model law and regulations. In accordance with MIPPA §104(a)(2), adoption and implementation of the NAIC model rules by the Department is necessary for the State of Texas to retain certification as a state with an approved regulatory program for Medicare supplement benefit plans.

The Department posted an informal working draft of the proposed amendments and new section on the Department's internet website from January 26, 2009, to February 27, 2009. The Department formally proposed the amendments and new sections in the April 17, 2009, issue of the *Texas Register* (34 TexReg 2432).

A public hearing on the rule proposal was not requested. In response to written comments on the published proposal, the Department has changed some of the proposed language in the text of the rule as adopted. Additionally, this adoption

includes a minor typographical correction in one provision. None of the changes made to the proposed text, either as a result of comment or as a result of necessary clarification, materially alters issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

The following changes are made to the proposed text:

The Department has modified proposed §3.3306(b)(5)(B) – (G) and (K) to clarify that references to the Medicare Part A Deductible in those subparagraphs are referring to the "coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period." Therefore, all references to §3.3306(a)(3)(A) in §3.3306(b)(5)(B) – (G) and (K) in the published proposal, read in this adoption as: "§3.3306(a)(3)(A)(i)." This clarification is necessary to reference the deductible amount with more exact citations to the appropriate clause.

The Department has modified §3.3308(c)(2)(E) and (F) as adopted to specify that Medicare supplement policies or certificates with an effective date for coverage of June 1, 2010, or later must contain the new outline of coverage. This change is the result of a commenter's concern that excluding the effective dates for coverage from these paragraphs creates ambiguity in the rule. The effective date language is consistent with the federal requirements outlined in MIPPA, with the NAIC Model Regulation, and with language used elsewhere in the rule as adopted. While carriers must include the amended Outline of Coverage form with policies sold with an effective date for coverage of June 1, 2010 or later, carriers are not precluded from issuing or delivering such policies or certificates to consumers prior to that date. As adopted, §3.3308(c)(2)(E) reads: "(E) The commissioner adopts by reference the Outline of Coverage form, Form

No. LHL 050 Rev. 06/09, which contains a chart of benefits for each of the standard Medicare supplement plans and required disclosures applicable to policies sold with an effective date for coverage of June 1, 2010 or later. The form is available at www.tdi.state.tx.us/forms/form10other.html." As adopted, §3.3308(c)(2)(F) reads: "(F) The commissioner adopts by reference the Outline of Coverage form, Form No. LHL 050 Rev. 12/04, which contains a chart of benefits for each of the standard Medicare supplement plans and required disclosures applicable to policies sold with an effective date for coverage prior to June 1, 2010, and on or after March 1, 1992. The form is available at www.tdi.state.tx.us/forms/form10other.html."

In addition, the Department has modified §3.3326 as adopted to provide that the effective date for the applicability of the section is July 1, 2009, in lieu the proposed May 21, 2009, effective date. As adopted, the first sentence of §3.3326 reads: "This section applies to all Medicare supplement policies and certificates with policy years beginning on or after July 1, 2009." Government Code §2001.036(a)(3), provides that "if a federal statute or regulation requires that a state agency implement a rule by a certain date, the rule is effective on the prescribed date." Section 104(d)(4)(A)(ii) of GINA, provides that the latest date for which a state must conform its regulations to the requirements of GINA is July 1, 2009. Compliance with the July 1, 2009, deadline is necessary for the State of Texas to retain certification as a state with an approved regulatory program for Medicare supplement benefit plans under 42 U.S.C. 1395ss. In addition, the Department has determined that certification as a state with an approved regulatory program for Medicare supplement benefit plans under 42 U.S.C. 1395ss is of vital importance to the Medicare supplement consumers of this state. A lapse in certification

would cause extreme uncertainly in the Medicare supplement market regarding regulatory authority of the Department to enforce its regulatory program for Medicare supplement benefit plans. A lapse in certification would cause imminent peril to the health and welfare of Medicare supplement beneficiaries who rely on this Department to regulate Medicare supplement insurance plans and to protect the consumers of this state from unscrupulous business practices in the Medicare supplement market. For the foregoing reasons, §3.3326 as adopted will be effective July 1, 2009. This modification, however, does not alter the applicability of §104(c) of GINA, which provides that the federal statute is applicable to Medicare supplement policies and certificates with policy years beginning on or after May 21, 2009. The Department has also made a typographical correction to lower case the initial letter in the first word of §3.3326(7)(B) as adopted.

The following paragraphs provide a brief summary as well as an analysis of the reasons for the adopted amendments and new section.

The adopted amendments to §3.3303 are necessary to add definitions for “1990 Standardized Medicare supplement benefit plan,” “2010 Standardized Medicare supplement benefit plan,” and “Pre-Standardized Medicare supplement plan” in paragraphs (1), (2), and (21). These terms are used in the new rules and in the NAIC model rules. The adopted amendments also redesignate the remaining definitions accordingly.

The adopted amendment to §3.3306(a) is necessary to provide minimum benefit standards for the new 2010 Standardized Medicare supplement benefit plan policies or certificates. Adopted §3.3306(a)(1)(A) is necessary to specify restrictions and

exceptions for the exclusion of preexisting conditions. Adopted §3.3306(a)(1)(B) is necessary to prohibit a Medicare supplement policy or certificate from indemnifying against losses resulting from sickness on a different basis than losses resulting from accidents. Adopted §3.3306(a)(1)(C) is necessary to provide that cost-sharing provisions in the plans must be amended to conform to applicable Medicare deductibles, copayments and benefit amounts as necessary. Adopted §3.3306(a)(1)(D) is necessary to restrict termination of coverage of a spouse to nonpayment of premium and to prohibit cancellation and nonrenewal by the insurer solely on the grounds of deterioration of health. Adopted §3.3306(a)(1)(E) is necessary to specify that polices must be guaranteed renewable, to provide restrictions on plan cancellation and to include provisions for continued coverage in cases where a policy is terminated by the group policyholder. Adopted §3.3306(a)(1)(F) is necessary to specify the restrictions on the determination and effect of a continuous loss. Adopted §3.3306(a)(1)(G) is necessary to specify the conditions for suspension and reinstitution of coverage in cases where the policyholder becomes eligible for or loses eligibility for benefits under the Social Security Act. Adopted §3.3306(a)(2) is necessary to provide that issuers must offer a policy or certificate including only the enumerated basic core package of benefits in addition to any of the standardized Medicare supplement insurance plans that may be offered. The basic core package of benefits is described in §3.3306(a)(2)(A) – (F) and includes coverage of Part A Medicare eligible expenses for hospitalization in various situations, coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood, coverage for the coinsurance amount of Medicare eligible expenses under Part B, and coverage of cost sharing for all Part A

Medicare eligible hospice and respite care expenses. Adopted §3.3306(a)(3) is necessary to specify standards for additional benefits that must be included in Plans B, C, D, F, F with High Deductible, G, M, and N. The additional benefits are described in §3.3306(a)(3)(A) – (E) and include required additional coverage for the Medicare Part A inpatient hospital deductible, coverage under Part A for post-hospital skilled nursing facility care, coverage for the Medicare Part B deductible, coverage for Medicare Part B excess charges, and coverage for medically necessary emergency care in a foreign country.

The adopted amendment to §3.3306(b) is necessary to set forth the additional standards for the issuance of the new 2010 Standardized Medicare supplement benefit plan policies and certificates, to provide a detailed description for each of the new benefit plans, and to address a procedure for the addition of new or innovative benefits to a standardized plan. Adopted §3.3306(b)(1) is necessary to require an issuer to offer a policy form or certificate form with only the basic core benefits and to also offer either standardized benefit Plan C or standardized benefit Plan F if the issuer makes available any additional benefits described in §3.3306(a)(3) or standardized benefit Plan K or standardized benefit Plan L. Adopted §3.3306(b)(2) is necessary to restrict the sale of Medicare supplement plans to the plans (Plans A – D, F, F with High Deductible, G, and K – N) provided in the rules and to clarify that no other groups, packages, or combination of benefits may be offered. Adopted §3.3306(b)(3) is necessary to provide a uniformity requirement for plan structure, language and format. Adopted §3.3306(b)(4) is necessary to allow plan designations to be modified by the issuer to the extent permitted by law. Adopted §3.3306(b)(5) is necessary to provide a detailed

description for each of the 2010 Standardized Benefit Plans (Plans A – D, F, F with High Deductible, G, and K – N). Adopted §3.3306(b)(6) is necessary to allow issuers to provide, upon Departmental approval, new or innovative benefits with a standardized plan, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. Under adopted §3.3306(b)(6), the following requirements apply to any new or innovative benefits: (i) they must include only benefits that are appropriate to Medicare supplement insurance, (ii) they must be new or innovative, (iii) they must not be otherwise available; (iv) they must be cost-effective; (v) the approval of the new or innovative benefits must not adversely impact the goal of Medicare supplement simplification; (v) they must not include an outpatient prescription drug benefit; and (vi) they cannot be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

Reorganization and structural changes made to the standardized plans described in adopted §3.3306(b)(5) are necessary to include the elimination of Plan E, Plans H – J, and High-Deductible Plan J, the addition of Plans M and N, and the restructuring of Plans D and G. Prescription drug benefits were removed from the eliminated plans by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. In addition, the NAIC removed the Preventative Care and At-Home Recovery benefits from the standardized plans because of under-utilization and the lesser need for these types of benefits. These benefits were removed by the NAIC after considerable discussion and collaboration among policymakers and stakeholders during the reorganization of the plans. Upon removal of prescription drug benefits under the MMA and removal of the Preventative Care and At-Home Recovery benefits during

reorganization under MIPPA, the eliminated plans were duplicative of other plans and became unnecessary. Plans D and G were retained but were necessarily restructured to reflect these benefit changes. During the reorganization process, the new plans were designed to give beneficiaries new options for higher cost-sharing with a lower premium. New Plan M provides 50% coverage of the Part A deductible and no coverage of the Part B deductible. New Plan N provides 100% coverage of the Part A deductible and no coverage of the Part B deductible.

For transitional purposes, the minimum benefit standards for the 1990 Standardized Medicare supplement benefit plan policies or certificates and the composition requirements of those plans are included in §3.3306(c) and (d). Adopted new §3.3306(c) corresponds to the old §3.3306(1) – (3) and adopted new §3.3306(d) corresponds to the old §3.3306(4) – (5). No significant changes were made to the text of those renumbered sections, except that §3.3306(c)(3)(K) is deleted and moved to 3.3306(d)(2)(O) without changes. This amendment is necessary to conform the existing rules to the structure of the NAIC model rules.

The adopted amendments to §3.3308(c)(1) and (2) are necessary to update and correct internal references, delete the existing outline of coverage provided in existing Figure: 28 TAC §3.3308(c)(2)(D), and adopt by reference form LHL 050 Rev. 12/04 and form LHL 050 Rev. 06/09. The new outline of coverage specified in form LHL 050 Rev. 06/09, which is adopted by reference in new §3.3308(c)(2)(E), is necessary to provide a detailed description of plan benefits for all plans that must be provided to all applicants. The new outline of coverage, which follows the same format as the existing outline of coverage in form LHL 050 Rev. 12/04, contains information regarding the new plans

and, where applicable, dollar amounts have been updated to show amounts paid by Medicare for the current calendar year. Issuers are required to update the dollar amounts paid by Medicare for future calendar years under the adopted amendment to §3.3308(c)(2)(A). The existing outline of coverage, formerly provided in Figure: 28 TAC §3.3308(c)(2)(D), is provided without change in form LHL 050 Rev. 12/04 and is adopted by reference for transitional purposes in new §3.3308(c)(2)(F).

The adopted amendments to §3.3322 are necessary to increase the number of additional policy certificate forms of the same type of policy that an issuer may offer and provide additional exceptions to the prohibition against the offering of multiple forms of the same type. Typically, an issuer may not file for approval of more than one form of a policy or certificate of each type. The amendments provide two new exceptions to the prohibition against multiple forms of the same type. Up to four policy forms of the same type may be offered for the addition of either direct response or agent marketing methods and for the addition of either guaranteed issue or underwritten coverage. These amendments are necessary to update the existing rules to conform to the additional policy standards provided for in the NAIC model rules.

Adopted new §3.3326 is necessary to comply with the GINA, which amends 42 U.S.C. §1395ss to limit use of genetic testing and genetic information. Adopted new §3.3326 applies to all Medicare supplement policies and certificates with policy years beginning on or after July 1, 2009. The adopted new section is necessary to prohibit the use of genetic information in the issuance or pricing of a policy or certificate, including a prohibition on the imposition of any exclusion of benefits based on a pre-existing condition on the basis of genetic information. The new section is additionally

necessary to prohibit an issuer from requiring or requesting that an individual or a family member undergo genetic testing except under strict conditions for research purposes. Conditions include requirements that: (i) the request is made pursuant to research that complies with 45 C.F.R 46 or equivalent federal regulations and any applicable state or local law; (ii) the issuer clearly indicates to the individual that the request is voluntary and will have no effect on enrollment status or premium or contribution amounts; (iii) the genetic information shall not be used for purposes related to underwriting, eligibility, premium rates, issuance, renewal or replacement; (iv) the issuer notifies the Commissioner in writing, and (v) the issuer complies with other such conditions as the Commissioner may by regulation require. The new section also includes several definitions for terms frequently used within the new section. These definitions are necessary for purposes of clarity in implementing, enforcing, and complying with the §3.3326 prohibitions.

In addition to the foregoing adopted amendments and new section, minor changes have been made throughout the sections that are necessary to correct form and grammar, to make clarifications, to correct citations, to update examples and references to form numbers, and to organize the sections in conformity with the NAIC model rules.

3. HOW THE SECTIONS WILL FUNCTION.

§3.3303. Definitions. Section §3.3303 adds definitions for frequently used terminology in the subchapter and renumbers paragraphs as necessary for inclusion of the new definitions. New paragraph (1) defines “1990 Standardized Medicare

supplement benefit plan" to refer to policies issued on or after March 1, 1992, the effective date for plan revisions made in conformity with the Omnibus Budget Reconciliation Act of 1990 (OBRA). New paragraph (2) defines "2010 Standardized Medicare supplement benefit plan" to refer to policies with an effective date for coverage on or after June 1, 2010. New paragraph (21) defines "Pre-Standardized Medicare supplement plan" to refer to policies issued prior to March 1, 1992, the effective date for plan revisions made in conformity to OBRA.

§3.3306. Minimum Benefit Standards. Section §3.3306 provides minimum benefit standards for the new 2010 Standardized Medicare supplement benefit plan policies or certificates and sets forth the additional standards for the issuance of the new 2010 Standardized Medicare supplement benefit plan policies and certificates, a detailed description for each of the new benefit plans, and a procedure for the addition of new or innovative benefits to a standardized plan. Adopted §3.3306(a)(1)(A) specifies restrictions and exceptions for the exclusion of preexisting conditions. Adopted §3.3306(a)(1)(B) prohibits a Medicare supplement policy or certificate from indemnifying against losses resulting from sickness on a different basis than losses resulting from accidents. Adopted §3.3306(a)(1)(C) provides that cost-sharing provisions in the plans must be amended to conform to applicable Medicare deductibles, copayments and benefit amounts as necessary. Adopted §3.3306(a)(1)(D) restricts termination of coverage of a spouse to nonpayment of premium and prohibits cancellation and nonrenewal by the insurer solely on the grounds of deterioration of health. Adopted §3.3306(a)(1)(E) specifies that polices must be guaranteed renewable, provides restrictions on plan cancellation and includes provisions for continued

coverage in cases where a policy is terminated by the group policyholder. Adopted §3.3306(a)(1)(F) specifies the restrictions on the determination and effect of a continuous loss. Adopted §3.3306(a)(1)(G) specifies the conditions for suspension and reinstitution of coverage in cases where the policyholder becomes eligible for or loses eligibility for benefits under the Social Security Act. Adopted §3.3306(a)(2) requires issuers to offer a policy or certificate including only the enumerated basic core package of benefits in addition to any of the standardized Medicare supplement insurance plans that may be offered. The basic core package of benefits is described in §3.3306(a)(2)(A) – (F) and includes coverage of Part A Medicare eligible expenses for hospitalization in various situations, coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood, coverage for the coinsurance amount of Medicare eligible expenses under Part B, and coverage of cost sharing for all Part A Medicare eligible hospice and respite care expenses. Adopted §3.3306(a)(3) specifies standards for additional benefits that must be included in Plans B, C, D, F, F with High Deductible, G, M, and N. The additional benefits are described in §3.3306(a)(3)(A) – (E) and include required additional coverage for the Medicare Part A inpatient hospital deductible, coverage under Part A for post-hospital skilled nursing facility care, coverage for the Medicare Part B deductible, coverage for Medicare Part B excess charges, and coverage for medically necessary emergency care in a foreign country.

Adopted §3.3306(b)(1) requires an issuer to offer a policy form or certificate form with only the basic core benefits and also offer either standardized benefit Plan C or standardized benefit Plan F if the issuer makes available any additional benefits described in §3.3306(a)(3) or standardized benefit Plan K or standardized benefit Plan

L. Adopted §3.3306(b)(2) restricts the sale of Medicare supplement plans to the plans (Plans A – D, F, F with High Deductible, G, and K – N) provided in the rules and clarifies that no other groups, packages, or combination of benefits may be offered. Adopted §3.3306(b)(3) mandates a uniformity requirement for plan structure, language and format. Adopted §3.3306(b)(4) allows plan designations to be modified by the issuer to the extent permitted by law. Adopted §3.3306(b)(5) provides a detailed description for each of the 2010 Standardized Benefit Plans (Plans A – D, F, F with High Deductible, G, and K – N). Adopted §3.3306(b)(6) allows issuers to provide, upon Departmental approval, new or innovative benefits with a standardized plan, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. Under adopted §3.3306(b)(6), the following requirements apply to any new or innovative benefits: (i) they must include only benefits that are appropriate to Medicare supplement insurance, (ii) they must be new or innovative, (iii) they must not be otherwise available; (iv) they must be cost-effective; (v) the approval of the new or innovative benefits must not adversely impact the goal of Medicare supplement simplification; (v) they must not include an outpatient prescription drug benefit; and (vi) they cannot be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan. Adopted §3.3306(b)(5) eliminates Plan E, Plans H – J, and High-Deductible Plan J, adds Plans M and N, and restructures Plans D and G.

The minimum benefit standards for the 1990 Standardized Medicare supplement benefit plan policies or certificates and the composition requirements of those plans are provided in §3.3306(c) and (d). Adopted new §3.3306(c) corresponds to the old

§3.3306(1) – (3) and adopted new §3.3306(d) corresponds to the old §3.3306(4) – (5). No significant changes were made to the text of those renumbered sections, except that §3.3306(c)(3)(K) is deleted and moved to 3.3306(d)(2)(O) without changes.

§3.3308. Required Disclosure Provisions. Adopted amendments to §3.3308(c)(1) and (2) update and correct internal references and adopt by reference form LHL 050 Rev. 12/04 and form LHL 050 Rev. 06/09. The new outline of coverage specified in form LHL 050 Rev. 06/09, which is adopted by reference in new §3.3308(c)(2)(E), provides a detailed description of plan benefits for all plans that must be provided to all applicants. The new outline of coverage contains information regarding the new plans and, where applicable, dollar amounts have been updated to show amounts paid by Medicare for the current calendar year. Issuers are required to update the dollar amounts paid by Medicare for future calendar years under the adopted amendment to §3.3308(c)(2)(A). The old outline of coverage, adopted by reference in §3.3308(c)(2)(F), is included for transitional purposes.

§3.3319. Standards for Marketing. Adopted amendments to §3.3319 update a statutory citation to conform to the non-substantive revised insurance code and to remove references to the 1990 Standardized benefit plans.

§3.3322. Filing and Approval of Policies, Certificates and Premium Rates; Discontinuance of Forms. Adopted amendments to §3.3322 increase the number of additional policy certificate forms of the same type of policy that an issuer may offer and provide additional exceptions to the prohibition against the offering of multiple forms of the same type. The amendments provide two new exceptions to the prohibition against multiple forms of the same type. Up to four policy forms of the same type may be

offered for the addition of either direct response or agent marketing methods and for the addition of either guaranteed issue or underwritten coverage. These amendments update the existing rule to conform to the additional policy standards provided for in the NAIC model rules.

§3.3326. Prohibition Against Use of Genetic Information and Requests for Genetic Testing in Medicare Supplement Policies. Adopted new §3.3326 applies to all Medicare supplement policies and certificates with policy years beginning on or after July 1, 2009. The adopted new section prohibits the use of genetic information in the issuance or pricing of a policy or certificate, including a prohibition on the imposition of any exclusion of benefits based on a pre-existing condition on the basis of genetic information. The new section additionally prohibits an issuer from requiring or requesting that an individual or a family member undergo genetic testing except under strict conditions for research purposes. Conditions include requirements that: (i) the request is made pursuant to research that complies with 45 C.F.R 46 or equivalent federal regulations and any applicable state or local law; (ii) the issuer clearly indicates to the individual that the request is voluntary and will have no effect on enrollment status or premium or contribution amounts; (iii) the genetic information shall not be used for purposes related to underwriting, eligibility, premium rates, issuance, renewal or replacement; (iv) the issuer notifies the Commissioner in writing, and (v) the issuer complies with other such conditions as the Commissioner may by regulation require. The new section also includes several definitions for terms frequently used within the new section.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

§3.3306. Minimum Benefit Standards

Comment: One commenter recommends that §3.3306(a)(1)(A)(i) be modified by inserting the phrase “for similar benefits” after the phrase “policy or certificate” and that §3.3306(a)(1)(A)(ii) be modified by inserting the phrase “similar to those contained in the original policy or certificate” after the word “benefits.” The commenter notes that inclusion of the two phrases would conform the Texas rules to Section 23 of the NAIC Model regulations (NAIC Model 651). The commenter suggests that inclusion of the language would protect against adverse selection that can occur if policyholders have the unfettered ability to switch policies and benefit packages when they experience changes in their health status.

Agency Response: The Department disagrees. No changes were made to Section 23 of NAIC Model 651 in response to MIPPA and GINA. Significantly, the Texas rules provide a greater protection than the NAIC model regulations to Texas consumers against preexisting conditions, waiting periods, elimination periods, and probationary periods when a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate. While the commenter is correct that inclusion of the two phrases would conform the Texas rules to the NAIC Model regulations, the Department is unaware of adverse selection problems occurring in the Texas market.

§3.3308. Required Disclosure Provisions.

Comment: One commenter recommends that §3.3308(c)(2)(E) be modified by adding the phrase “applicable to policies sold with an effective date for coverage of June 1, 2010, or later” to the end of the first sentence and that §3.3308(c)(2)(F) be modified by adding the phrase “applicable to polices sold with an effective date for coverage prior to June 1, 2010” to the end of the first sentence. The commenter suggests that adoption of this additional language would provide clarification that Medicare supplement policies or certificates with an effective date for coverage of June 1, 2010, or later must contain the new outline of coverage but that carriers are not precluded from issuing or delivering such policies or certificates to consumers prior to that date. The commenter also contends that this approach is consistent with the federal requirements outlined in MIPPA and with the NAIC Model Regulation.

Agency Response: The Department agrees and has made the suggested changes to §§3.3308(c)(2)(E) and (F) as adopted. In addition, the Department has further clarified that §3.3308(c)(2)(F) as adopted is only “applicable to polices sold with an effective date for coverage prior to June 1, 2010, and on or after March 1, 1992.”

§3.3322. Filing and Approval of Policies, Certificates and Premium Rates; Discontinuance of Forms.

Comment: One commenter asks whether the 2010 Standardized benefit plans should be filed as a new product independent of the 1990 Standardized benefit plans.

Agency Response: Yes, the 2010 Standardized benefit plans should be filed as a new product. Since the 2010 Standardized benefit plans are new plans, separate and distinct from the 1990 Standardized benefit plans, the 2010 Standardized benefit plans

will operate independently from the 1990 Standardized benefit plans. The Department reminds carriers that all policy forms or certificate forms for use in Texas must be filed and approved in accordance with §3.3322.

Comment: One commenter questions whether a 2010 Standardized benefit plan may be filed as an endorsement to an existing plan for policyholders who wish to convert from a 1990 Standardized benefit plan.

Agency Response: Since the 2010 Standardized benefit plans are new plans, separate and distinct from the 1990 Standardized benefit plans, the 2010 Standardized benefit plans must be offered independently from and may not be offered to consumers as an endorsement to the 1990 Standardized benefit plans. In addition, the Department notes that adding an endorsement to a 1990 Standardized benefit plan on or after June 1, 2010, would be in violation of the prohibition against issuing or issuing for delivery a 1990 Standardized benefit plans on or after June 1, 2010.

Comment: One commenter has an inquiry about the applicability of §3.3322(e) to the 1990 Standardized benefit plans and whether or not there are any requirements that carriers enter the market for the 2010 Standardized benefit plans.

Agency Response: Since the 1990 Standardized benefit plans are being discontinued by operation of law, §3.3322(e) will be inapplicable to the plans on or after June 1, 2010. While carriers may not offer a 2010 Standardized benefit plan to consumers prior to the filing and approval of the plan forms, a carrier may elect to postpone the offering of 2010 Standardized benefit plans.

Comment: One commenter asks whether the 2010 Standardized benefit plans will be rated independently from the 1990 Standardized benefit plans for both initial premium rates and premium rate increases.

Agency Response: Since the 2010 Standardized benefit plans are new plans, separate and distinct from the 1990 Standardized benefit plans, the initial premium rates for the 2010 Standardized benefit plans should be developed independently from the 1990 Standardized benefit plans. However, rate filings continue to be subject to compliance with §3.3307. While initial premium rates are not subject to any pooling requirements under the rules, subsequent filings, including annual filings made in compliance with §3.3307(e), must comply with §3.3307(d). Section 3.3307(d) provides, in part, that "policy forms, whether for open or closed blocks of business, providing similar benefits shall be combined" and that "[o]nce policy forms have been combined, they remain so for all rate purposes." The Department has determined that a 2010 Standardized benefit plan with the same letter designation as a 1990 Standardized benefit plan provides similar benefits for the purposes of determining compliance with §3.3307. The Department reminds carriers that all premium rates for the 2010 Standardized benefit plans must be filed and approved in accordance with §3.3322(c) and that premium rate increases must be filed and approved in accordance with §3.3323.

General.

Comment: One commenter commends the Department for providing Texas consumers with policies that are in compliance with federal law and which also provide protection against the adverse use of genetic information.

Agency Response: The Department appreciates the supportive comment.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For with changes: America's Health Insurance Plans.

For without changes: Office of Public Insurance Counsel.

Neither for nor against: Great American Financial Resources, Inc.

Against: None.

6. STATUTORY AUTHORITY. The amendments are adopted pursuant to the Insurance Code §§1652.005, 1652.051(a)(2), 1652.151, 1652.152 and 36.001. Section 1652.005 provides that the Commissioner shall adopt reasonable rules necessary and proper to carry out Chapter 1652, including rules adopted in accordance with federal law relating to the regulation of Medicare supplement benefit plan coverage that are necessary for this state to obtain or retain certification as a state with an approved regulatory program. Section 1652.051(a)(2) provides, in part, that the Commissioner shall adopt reasonable rules to establish specific standards for provisions in Medicare supplement benefit plans and standards for facilitating comparisons of different Medicare supplement benefit plans in accordance with any model rules and regulations required by federal law. Section 1652.151 provides that rules adopted under §1652.152 must include provisions and requirements that are at least equal to those required by

federal law. Section 1652.152 requires an outline of coverage to be delivered to an applicant when the applicant applies for coverage and provides that the Commissioner by rule shall prescribe the format and content of the outline of coverage. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

7. TEXT.

§3.3303. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) 1990 Standardized Medicare supplement benefit plan, 1990 Standardized benefit plan, or 1990 plan--A group or individual policy of Medicare supplement insurance issued or issued for delivery on or after March 1, 1992, and with an effective date for coverage prior to June 1, 2010.

(2) 2010 Standardized Medicare supplement benefit plans, 2010 Standardized benefit plan, or 2010 plan--A group or individual policy of Medicare supplement insurance with an effective date for coverage on or after June 1, 2010.

(3) Applicant--

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

(B) In the case of a group Medicare supplement policy, the proposed certificate holder.

(4) Bankruptcy--The situation that occurs 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 this state.

(5) Certificate--Any certificate issued under a group Medicare supplement policy, which certificate has been delivered or issued for delivery in this state regardless of the place where the policy was delivered or issued for delivery.

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

(7) Creditable coverage--Any coverage of an individual as defined in §21.1101 of this title (relating to Definitions).

(8) Employee welfare benefit plan--A plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

(9) Health Maintenance Organization (HMO)--An entity as defined in 42 U.S.C. §300e(a).

(10) Insolvency--The situation which occurs when an issuer has had an order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

(11) Issuer--An insurance company, fraternal benefit society, health care service plan, health maintenance organization, or any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

(12) Medicaid--Grants to States for Medical Assistance Programs, Title XIX of the Social Security Act Amendments of 1965 as Then Constituted or Later Amended.

(13) Medicare--The Health Insurance for the Aged Act, Title XVIII of the Social Security Act Amendments of 1965 as Then Constituted or Later Amended.

(14) Medicare Advantage organization--An entity as defined in 42 U.S.C. §1395w-28(a)(1).

(15) Medicare Advantage plan--A plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. §1395w-28(b)(1), and includes:

(A) coordinated care plans which provide health 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;

(B) medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and

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

(16) Medicare Advantage private fee-for-service plan--An entity as defined in 42 U.S.C. §1395w-28(b)(2).

(17) MMA--The Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(18) Medicare Select policy or Medicare Select certificate--A Medicare supplement policy or certificate, respectively, that contains restricted network provisions.

(19) Medicare supplement policy--A group or individual policy of accident and sickness insurance or a subscriber contract of a hospital service corporation subject to the Insurance Code, Chapter 20, or, to the extent required by federal law, an evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act, which policy, subscriber contract, or such evidence of coverage 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. The term does not include:

(A) a policy, contract, subscriber contract, or evidence of coverage 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 combination thereof, or for members or former members, or combination thereof, of the labor organizations;

(B) a policy or health care benefit plan including a policy or contract of group insurance or group contract of a hospital service corporation subject to the Insurance Code, Chapter 20, or group evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act, when such policy or plan is not marketed or held to be a Medicare supplement policy or benefit plan; or

(C) an individual or group evidence of coverage issued pursuant to a contract under the Federal Social Security Act, §1876 (42 U.S.C. §§1395, et seq.) by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Texas Insurance Code, Chapters 20A and 843);

(D) a Medicare Advantage plan established under Medicare Part C;

(E) an Outpatient Prescription Drug plan established under Medicare Part D; or

(F) a Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under §1833(a)(1)(A) of the Federal Social Security Act (42 U.S.C. §§1395, et seq.)

(20) Point-of-service--A benefit option as defined in 42 C.F.R. §422.2.

(21) Pre-Standardized Medicare supplement benefit plan, Pre-Standardized benefit plan or Pre-Standardized plan--A group or individual policy of Medicare supplement insurance issued or issued for delivery prior to March 1, 1992.

(22) Provider-Sponsored organization--An entity as defined in 42 U.S.C. §1395w-25(d)(1).

(23) Qualified actuary--An actuary who is a member of either the Society of Actuaries or the American Academy of Actuaries.

(24) Secretary--The Secretary of the United States Department of Health and Human Services.

§3.3306. Minimum Benefit Standards.

(a) Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued or Issued for Delivery with an Effective Date for Coverage on or After June 1, 2010. This section specifies the minimum standards applicable to all Medicare supplement policies or certificates issued or issued for delivery in this state

with an effective date for coverage on or after June 1, 2010. No insurance policy, subscriber contract, certificate, or evidence of coverage may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy unless the policy, contract, certificate, or evidence of coverage meets the applicable standards in paragraphs (1) - (3) of this subsection. No issuer may offer or issue any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued or issued for delivery with an effective date prior to June 1, 2010, remain subject to the requirements of subsections (c) and (d) of this section. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(1) General standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this subchapter, the Insurance Code Chapter 1652, and any other applicable law.

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

(i) 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 condition 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.

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

(iii) If a Medicare supplement policy or certificate is issued or issued for delivery to an applicant who qualifies under §3.3312(b) of this subchapter (relating to Guaranteed Issue for Eligible Persons) or §3.3324(a) of this subchapter (relating to Open Enrollment), the issuer shall reduce the period of any preexisting condition exclusion as required by §3.3312(a)(2) of this subchapter and §3.3324(c) and (d) of this subchapter.

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

(C) 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, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

(D) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event

specified for termination of coverage of the insured, other than the nonpayment of premium, or be cancelled or nonrenewed by the insurer solely on the grounds of deterioration of health.

(E) Each Medicare supplement policy shall be guaranteed renewable and shall comply with the provisions of clauses (i) – (v) of this subparagraph.

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

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

(iii) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided in clause (iv) of this subparagraph, the issuer shall offer certificate holders an individual Medicare supplement policy which at the option of the certificate holder:

(I) provides for continuation of the benefits contained in the group policy; or

(II) provides for benefits that otherwise meet the requirements of this subparagraph.

(iv) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(I) offer the certificate holder the conversion opportunity described in clause (iii) of this subparagraph; or

(II) at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(v) 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.

(F) 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 must not be considered in determining a continuous loss.

(G) A Medicare supplement policy or certificate shall comply with clauses (i) – (iv) of this subparagraph:

(i) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period not to exceed 24 months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the

policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to assistance.

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

(iii) 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 or certificate holder if the policyholder or certificate holder 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 or certificate holder provides notice of loss of coverage within 90 days after the date of the loss.

(iv) Reinstitution of coverages shall comply with subclauses (I) – (III) of this clause.

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

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

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

(2) Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M and N. Every issuer of Medicare supplement insurance benefit plans 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. These plans include:

(A) 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;

(B) 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;

(C) upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent 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;

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

(E) 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;

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

(3) Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by subsection (b) of this section.

(A) Medicare Part A Deductible:

(i) coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period; or

(ii) coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period.

(B) Skilled Nursing Facility Care: coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a

Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(C) Medicare Part B Deductible: coverage for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

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

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

(b) Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued or Issued for Delivery with an Effective Date for Coverage on or After June 1, 2010. The following standards are applicable to all Medicare supplement policies or certificates issued or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No

insurance policy, subscriber contract, certificate, or evidence of coverage may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy unless the policy, contract, certificate, or evidence of coverage complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued or issued for delivery with an effective date for coverage before June 1, 2010, remain subject to the requirements of subsections (c) and (d) of this section.

(1) An issuer of a Medicare supplement policy or certificate shall comply with subparagraphs (A) and (B) of this paragraph:

(A) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in subsection (a)(2) of this section.

(B) If an issuer makes available any of the additional benefits described in subsection (a)(3) of this section, or offers standardized benefit Plans K or L (as described in paragraph (5)(H) and (I) of this subsection), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in subparagraph (A) of this paragraph, a policy form or certificate form containing either standardized benefit Plan C (as described in paragraph (5)(C) of this subsection) or standardized benefit Plan F (as described in paragraph (5)(E) of this subsection).

(2) No groups, packages or combinations of Medicare supplement benefits other than those listed in this subsection shall be offered for sale in this state,

except as may be permitted in paragraph (6) of this subsection and in §3.3325 of this subchapter (relating to Medicare Select Policies, Certificates and Plans of Operation).

(3) Benefit plans shall be uniform in structure, language, and format, as well as designation, to the standard benefit plans listed in this paragraph and conform to the definitions in §3.3303 of this subchapter (relating to Definitions). Each benefit plan shall be structured in accordance with the format provided in subsection (a)(2) and (3) of this section; or, in the case of Plans K or L, in accordance with the format provided in paragraph (5)(H) or (I) of this subsection; and list the benefits in the order shown. For purposes of this subsection, “structure, language, and format” means style, arrangement and overall content of a benefit.

(4) In addition to the benefit plan designations required in paragraph (3) of this subsection, an issuer may use other designations to the extent permitted by law.

(5) The make-up of 2010 Standardized Benefit Plans is as specified in subparagraphs (A) – (K) of this paragraph.

(A) Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in subsection (a)(2) of this section.

(B) Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefits as defined in subsection (a)(2) of this section, plus 100 percent of the Medicare Part A deductible as defined in subsection (a)(3)(A)(i) of this section.

(C) Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefits as defined in subsection (a)(2) of

this section, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in subsection (a)(3)(A)(i), (B), (C), and (E) of this section, respectively.

(D) Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefits (as defined in subsection (a)(2) of this section), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in an foreign country as defined in subsection (a)(3)(A)(i), (B), and (E) of this section, respectively.

(E) Standardized Medicare supplement (regular) Plan F shall include only the following: The basic (core) benefits as defined in subsection (a)(2) of this section, plus 100 percent of the Medicare Part A deductible, the skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in subsection (a)(3)(A)(i), (B), (C), (D), and (E) of this section, respectively.

(F) Standardized Medicare supplement Plan F With High Deductible shall include 100 percent of covered expenses following the payment of the annual deductible set forth in clause (ii) of this subparagraph.

(i) The basic (core) benefits as defined in subsection (a)(2) of this section, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in subsection (a)(3)(A)(i), (B), (C), (D), and (E) of this section, respectively.

(ii) The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by regular Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1,500 and shall be adjusted annually by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(G) Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefits as defined in subsection (a)(2) of this section, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in subsection (a)(3)(A)(i), (B), (D), and (E), respectively.

(H) Standardized Medicare supplement Plan K is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(i) Part A Hospital Coinsurance, 61st through 90th days: Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(ii) Part A Hospital Coinsurance, 91st through 150th days: Coverage of 100 percent 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;

(iii) Part A Hospitalization After 150 Days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(iv) Medicare Part A Deductible: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in clause (x) of this subparagraph;

(v) Skilled Nursing Facility Care: Coverage for 50 percent 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 clause (x) of this subparagraph;

(vi) Hospice Care: Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in clause (x) of this subparagraph;

(vii) Blood: Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in

accordance with federal regulations until the out-of-pocket limitation is met as described in clause (x) of this subparagraph;

(viii) Part B Cost Sharing: Except for coverage provided in clause (ix) of this subparagraph, coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in clause (x) of this subparagraph;

(ix) Part B Preventive Services: Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(x) Cost Sharing After Out-of-Pocket Limits: Coverage of 100 percent 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.

(I) Standardized Medicare supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(i) the benefits described in subparagraph (H)(i), (ii), (iii), and (ix) of this paragraph;

(ii) the benefit described in subparagraph (H)(iv), (v), (vi), (vii), and (viii) of this paragraph, but substituting 75 percent for 50 percent; and

(iii) the benefit described in subparagraph (H)(x) of this subsection, but substituting $2000 for $4000.

(J) Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in subsection (a)(2) of this section, plus 50 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in subsection (a)(3)(A)(ii), (B), and (E) of this section, respectively.

(K) Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in subsection (a)(2) of this section, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in subsection (a)(3)(A)(i), (B), and (E) of this section, respectively, with copayments in the following amounts:

(i) the lesser of $20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and

(ii) the lesser of $50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(6) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable

standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

(c) Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued or Issued for Delivery on or After March 1, 1992, and with an Effective Date for Coverage Prior to June 1, 2010. No insurance policy, subscriber contract, certificate, or evidence of coverage may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy unless the policy, contract, certificate, or evidence of coverage meets the applicable standards in paragraphs (1) – (3) of this subsection. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(1) General standards. The following standards apply to Medicare supplement policies and are in addition to all other requirements of this subchapter, the Insurance Code Chapter 1652, and any other applicable law.

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

(i) 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 condition 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.

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

(iii) If a Medicare supplement policy or certificate is issued or issued for delivery to an applicant who qualifies under §3.3312(b) of this subchapter or §3.3324(a) of this subchapter, the issuer shall reduce the period of any preexisting condition exclusion as required by §3.3312(a)(2) of this subchapter and §3.3324(c) and (d) of this subchapter.

(B) A Medicare supplement policy may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(C) A Medicare supplement policy shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and

copayment percentage factors. Premiums may be modified to correspond with such changes.

(D) No Medicare supplement policy shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium, or be cancelled or nonrenewed by the insurer solely on the grounds of deterioration of health.

(E) Each Medicare supplement policy shall be guaranteed renewable and shall comply with the provisions of clauses (i) - (v) of this subparagraph.

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

(ii) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided in clause (iv) of this subparagraph, the issuer shall offer certificate holders Medicare supplement coverage which provides benefits as set out in subclause (I) or (II) of this clause, as follow:

(I) an individual Medicare supplement policy which (at the option of the certificate holder):

(-a-) provides for continuation of the benefits contained in the group policy; or

(-b-) provides for benefits that otherwise meet the requirement of this paragraph; or

(II) continuation of benefits under the group plan until there are no longer any certificate holders remaining who have opted for continuation of benefits under the group policy terminated by the policyholder.

(iii) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(I) offer the certificate holder conversion opportunity described in clause (ii) of this subparagraph; or

(II) at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(iv) 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 of preexisting conditions that would have been covered under the group policy being replaced.

(v) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the MMA, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

(F) Termination of a Medicare supplement policy 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 payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

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

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

(ii) Each Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder or certificate holder if the policyholder or certificate holder 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 or certificate shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder or certificate holder provides notice of

loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(iii) Reinstitution of such coverages shall provide for the following:

(I) waiver of any waiting period with respect to treatment of preexisting conditions;

(II) resumption of coverage which 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 the suspension; and

(III) classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(H) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the MMA, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

(2) Standards for the basic (core) benefits common to benefit plans A - J. Every issuer shall make available a policy or certificate including only the basic "core" package of benefits described in subparagraphs (A) - (E) of this paragraph 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. The basic core benefits shall consist of the following:

(A) coverage for 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;

(B) coverage for Part A Medicare eligible expenses, to the extent not covered by Medicare, incurred as daily hospital charges during use of Medicare lifetime hospital inpatient reserve days;

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

(D) coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulation) unless replaced in accordance with federal regulation; and

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

(3) Standards for Additional Benefits. The additional benefits as uniformly defined in subparagraphs (A) – (J) of this paragraph and in subsection (d)(2)(O) of this section shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided in subsection (d)(2)(A) - (I) of this section.

(A) Medicare Part A Deductible--Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

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

(C) Medicare Part B Deductible--Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

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

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

(F) Basic Outpatient Prescription Drug Benefit--Coverage for 50% of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent

not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

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

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

(I) Preventive Medical Care Benefit or Services--Coverage for the preventive health services described in clauses (i) and (ii) of this subparagraph. Coverage for preventive medical care benefits or services shall be for the actual charges up to 100% of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare:

(i) an annual clinical preventive medical history and physical examination that may include tests and services from clause (ii) of this subparagraph and patient education to address preventive health care measures;

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

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

(i) For purposes of this benefit, the following definitions in subclauses (I) - (IV) of this clause shall apply.

(I) 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.

(II) 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.

(III) 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.

(IV) 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 four hours in a 24-hour period of services provided by a care provider is one visit.

(ii) Coverage requirements and limitations.

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

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

(III) Coverage is limited to:

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

(-b-) the actual charges for each visit up to maximum coverage of $40 per visit;

(-c-) $1,600 per calendar year;

(-d-) seven visits in any one week;

(-e-) care furnished on a visiting basis in the insured's home;

(-f-) services provided by a care provider as defined in this section;

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

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

(iii) Coverage is excluded for:

(I) home care visits paid for by Medicare or other government programs; and

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

(d) Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued or Issued for Delivery on or After March 1, 1992 and with an Effective Date for Coverage Prior to June 1, 2010.

(1) Requirement of uniformity for all Medicare supplement benefit plans. An issuer shall make available only those groups, packages or combinations of Medicare supplement benefits as described in this section, unless otherwise permitted by provisions of subsection (d)(2)(O) of this section and in §3.3325 of this subchapter. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plan "A," defined as the basic core plan of benefits in subsection (c)(2)

of this section and described in paragraph (2)(A) of this subsection, and benefit plans "B" through "J," described in paragraph (2)(B) - (L) of this subsection. All benefit plans shall conform to the definitions set out in §3.3303 of this subchapter and §3.3304 of this subchapter (relating to Policy Definitions and Terms). Each benefit shall be structured in accordance with the format provided in subsection (c)(2) and (3) of this section. Each benefit plan shall list the benefits in the order shown in paragraph (2)(A) - (L) of this section. For purposes of this paragraph, "structure, language, and format" means style, arrangement and overall content of a benefit. In addition to the benefit plan designations required in this paragraph, an issuer may use other designations to the extent permitted by law.

(2) Make-up of Benefit Plans. Subparagraphs (A) – (O) of this paragraph set out the composition of benefit plans. Each benefit plan shall meet the requirements of this subchapter.

(A) Standardized Medicare Supplement Benefit Plan "A." Medicare supplement benefit Plan "A" shall include only the Core Benefits common to All Benefit Plans, as defined in subsection (c)(2) of this section.

(B) Standardized Medicare Supplement Benefit Plan "B." Medicare supplement benefit Plan "B" shall include only the Core Benefits as defined in subsection (c)(2) of this section, plus the Medicare Part A Deductible as defined in subsection (c)(3) of this section.

(C) Standardized Medicare Supplement Benefit Plan "C." Medicare supplement benefit Plan "C" shall include only the Core Benefit as defined in subsection (c)(2) of this section, 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 subsection (c)(3) of this section.

(D) Standardized Medicare Supplement Benefit Plan "D." Medicare supplement benefit Plan "D" shall include only the Core Benefit as defined in subsection (c)(2) of this section, 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 subsection (c)(3) of this section.

(E) Standardized Medicare Supplement Benefit Plan "E." Medicare supplement benefit Plan "E" shall include only the Core Benefit as defined in subsection (c)(2) of this section, 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 subsection (c)(3) of this section.

(F) Standardized Medicare Supplement Benefit Plan "F." Medicare supplement benefit Plan "F" shall include only the Core Benefit as defined in subsection (c)(2) of this section, plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, One Hundred Percent of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in subsection (c)(3) of this section.

(G) Standardized Medicare Supplement Benefit High Deductible Plan "F." 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 subsection (c)(2) of this section, plus the Medicare Part A Deductible, Skilled

Nursing Facility Care, Medicare Part B Deductible, 100% of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in subsection (c)(3) of this section. The annual high deductible Plan "F" deductible shall consist of out-of-pocket expenses, other than premiums for services covered by the Medicare supplement Plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be $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.

(H) Standardized Medicare Supplement Benefit Plan "G." Medicare supplement benefit Plan "G" shall include only the Core Benefit as defined in subsection (c)(2) of this section, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Eighty Percent of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in subsection (c)(3) of this section.

(I) Standardized Medicare Supplement Benefit Plan "H." Medicare supplement benefit Plan "H" shall include only the Core Benefit as defined in subsection (c)(2) of this section, 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 subsection (c)(3) of this section. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(J) Standardized Medicare Supplement Benefit Plan "I." Medicare supplement benefit Plan "I" shall include only the Core Benefit as defined in subsection (c)(2) of this section, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, One Hundred Percent 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 subsection (c)(3) of this section. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(K) Standardized Medicare Supplement Benefit Plan "J." Medicare supplement benefit Plan "J" shall include only the Core Benefit as defined in subsection (c)(2) of this section, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent 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 subsection (c)(3) of this section. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(L) Standardized Medicare Supplement Benefit High Deductible Plan "J." Medicare supplement benefit high deductible Plan "J" shall include 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 subsection (c)(2) of this section, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, 100% of the Medicare Part B Excess Charges, Extended Outpatient Prescription Drug Benefit, Medically Necessary

Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in subsection (c)(3) of this section. 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.

(M) Standardized Medicare supplement benefit Plan "K" shall include only the following:

(i) 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;

(ii) 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;

(iii) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum

benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

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

(v) 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 clause (x) of this subparagraph;

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

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

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

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

(x) 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 calendar year 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary.

(N) Standardized Medicare supplement benefit Plan "L" shall include only the following:

(i) The benefits described in subparagraph (M)(i), (ii), (iii) and (ix) of this paragraph;

(ii) The benefits described in subparagraph (M)(iv), (v), (vi), (vii) and (viii) of this paragraph, but substituting 75% for 50%; and

(iii) The benefit described in subparagraph (M)(x) of this paragraph, but substituting $2000 for $4000.

(O) Any benefit that an issuer may, with the prior approval of the commissioner, offer 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.

§3.3308. Required Disclosure Provisions.

(a) General rules.

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision must be consistent with the type of contract issued. The provisions 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 age of the policyholder.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the policyholder, or by which the issuer exercises a specifically reserved right under a Medicare supplement policy, or by which the issuer is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After the date of issue of the policy or certificate, any rider or endorsement which increases benefits or coverage with concomitant increase in premium during the policy term shall be agreed to in writing signed by the policyholder, unless the benefits are required by the minimum standards for Medicare supplement insurance policies, or unless 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 additional premium charge shall be set forth in the policy.

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

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions:

(A) the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations;"

(B) the policy or certificate shall define the term "preexisting condition" and shall provide an explanation of the term in its accompanying outline of coverage; and

(C) the policy or certificate shall include a provision explaining the reduction of the preexisting condition limitation for individuals that qualify under §3.3306(1)(A) of this title (relating to Minimum Benefit Standards), §3.3312(a)(2) of this title (relating to Guaranteed Issue to Eligible Persons), or §3.3324(c) and (d) of this title (relating to Open Enrollment).

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

(6) Issuers of accident and sickness policies, certificates, or subscriber contracts 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 of the United States Department of Health and Human Services in no smaller than 12-point type.

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

(B) If a Guide incorporating the latest statutory changes is not available from a government agency, companies may comply with this provision by modifying the latest available Guide to the extent required by applicable law.

(C) Except as provided in this section, delivery of the Guide shall be made whether or not such policies, certificates, subscriber contracts, or evidences of coverage are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this regulation.

(D) Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuer. Provided, however, issuers shall deliver the Guide to the applicant for a direct response Medicare supplement policy upon request, but not later than at the time the policy is delivered.

(7) Except as otherwise provided in this section, the terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import may not be used unless the policy is issued in compliance with §3.3306 of this title.

(b) Outline of coverage requirements for Medicare supplement policies.

(1) Issuers of Medicare supplement coverage in this state shall provide an outline of coverage to all applicants, including certificate holders under group policies, at the time application is presented to the prospective applicant, and, except for direct response policies, shall obtain an acknowledgment of receipt of such outline from the applicant.

(2) If a Medicare supplement policy or certificate is issued on a basis which would require revision of the outline of coverage delivered at the time of application, a substitute outline of coverage properly describing the policy or certificate actually issued shall accompany such policy or certificate when it is delivered and contain the following statement in no less than 12-point type, immediately above the company name: "Notice: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(c) Form for outline of coverage. In providing outlines of coverage to applicants pursuant to the requirements of subsection (b)(1) of this section, insurers shall use a form which complies with the requirements of this subsection. The outline of coverage must contain each of the following four parts in the following order: 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 in paragraphs (1) and (2) of this subsection in no less than 12-point type.

(1) All plans shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that

are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(2) The items in subparagraphs (A) - (C) of this paragraph shall be included in the outline of coverage in addition to the items specified in the plan-specific outline-of-coverage forms.

(A) Dollar amounts which are shown in parentheses for each of the plan-specific charts on the following pages are for the calendar year in which the charts were published. Issuers shall, for each plan offered, appropriately complete outline-of-coverage-chart statements about amounts to be paid by Medicare, the plan, and the covered person by replacing the amount in parentheses with the dollar amount corresponding to each covered service for the applicable calendar year benefit period.

(B) The outline of coverage must include an explanation of any limitations and exclusions. Those limitations and exclusions resulting from Medicare program provisions may be disclosed as such by reference and need not be explained in their entirety. All limitations and exclusions related to preexisting conditions, and all other limitations and exclusions not resulting from Medicare regulations must be fully explained in the outline of coverage.

(C) The outline of coverage must include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or the surrender of the policy or certificate. If the policy contains such provisions, a description of them must be included.

(D) The outline of coverage for Medicare Select policies or certificates shall include information regarding grievance procedures which meet the requirements of §3.3325(m) of this subchapter (relating to Medicare Select Policies, Certificates and Plans of Operation).

(E) The commissioner adopts by reference the Outline of Coverage form, Form No. LHL 050 Rev. 06/09, which contains a chart of benefits for each of the standard Medicare supplement plans and required disclosures applicable to policies sold with an effective date for coverage of June 1, 2010 or later. The form is available at www.tdi.state.tx.us/forms/form10other.html.

(F) The commissioner adopts by reference the Outline of Coverage form, Form No. LHL 050 Rev. 12/04, which contains a chart of benefits for each of the standard Medicare supplement plans and required disclosures applicable to policies sold with an effective date for coverage prior to June 1, 2010, and on or after March 1, 1992. The form is available at www.tdi.state.tx.us/forms/form10other.html.

(d) Notice requirements.

(1) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, every issuer providing Medicare supplement coverage to a resident of this state shall notify its policyholders, contract holders, and certificate holders of modifications it has made to Medicare supplement insurance policies, contracts, or certificates. The notice shall:

(A) include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement insurance policy, contract, or certificate; and

(B) inform each covered person as to when any premium adjustment is to be made due to changes in Medicare.

(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.

(3) The notice shall not contain or be accompanied by any solicitation.

(4) Issuers shall comply with any notice requirements of the MMA.

§3.3319. Standards for Marketing.

(a) Every issuer marketing Medicare supplement coverage in this state, directly or through its agents, shall establish marketing procedures to ensure that:

(1) any comparison of policies by its agents will be fair and accurate;

(2) excessive insurance is not sold or issued;

(3) all prospective policyholders are advised prior to the time an application is taken, that the basic "core" benefit package is available, including the contents of such basic "core" benefit package;

(4) every reasonable effort and inquiry is made to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance; and

(5) auditable procedures for verifying compliance with provisions of this section are in place and utilized.

(b) Every issuer marketing Medicare supplement coverage in this state, directly or through its agents, shall ensure that the following notice is prominently displayed by

type, stamp, or other appropriate means on the first page of the policy: "Notice to buyer: This policy may not cover all of your medical expenses."

(c) In addition to the practices prohibited in the Insurance Code Chapter 541, the following acts and practices are prohibited in the marketing of Medicare supplement policies or coverages in this state.

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

(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.

(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. This requirement is in addition to other regulations applicable to lead card advertising.

(4) Issuers may utilize additional benefit designations in the marketing of the benefit plans; however, such designations shall be accompanied by a clear statement as to the applicable benefit plan being marketed. Additional benefit designations shall not be deceptive or misleading.

§3.3322. Filing and Approval of Policies, Certificates and Premium Rates; Discontinuance of Forms.

(a) 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 Insurance Code and applicable regulations.

(b) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the MMA only with the commissioner in the state in which the policy or certificate was issued.

(c) 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 Insurance Code and this subchapter.

(d) Except as provided in paragraphs (1) – (4) of this subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan. For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy. An issuer may offer, with the approval of the commissioner, up to four policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(1) the inclusion of new or innovative benefits;

(2) the addition of either direct response or agent marketing methods;

(3) the addition of either guaranteed issue or underwritten coverage; and

(4) the offering of coverage to individuals eligible for Medicare by reason of disability.

(e) Except as provided in paragraph (1) of this subsection, 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 12 months.

(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.

(2) An issuer that discontinues the availability of a policy form or certificate form pursuant to paragraph (1) of this subsection 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 years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

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

(g) A change in the rating structure or methodology shall be considered a discontinuance under subsection (e)(1) of this section, unless the issuer complies with the following requirements:

(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.

(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.

(h) 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 §3.3307 of this title (relating to Loss Ratio Standards and Refund or Credit of Premiums), except that forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

§3.3326. Prohibition Against Use of Genetic Information and Requests for Genetic Testing in Medicare Supplement Policies. This section applies to all

Medicare supplement policies and certificates with policy years beginning on or after July 1, 2009.

(1) The definitions in subparagraphs (A) – (F) of this paragraph apply to this section only.

(A) "Issuer of a Medicare supplement policy or certificate" includes a third-party administrator, or other person acting for or on behalf of such issuer.

(B) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

(C) "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

(D) “Genetic services” means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

(E) “Genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term “genetic test” does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(F) “Underwriting purposes” means:

(i) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(ii) the computation of premium or contribution amounts under the policy;

(iii) the application of any pre-existing condition exclusion under the policy; and

(iv) other activities related to the issuance, renewal, or replacement of a contract of health insurance or health benefits.

(2) An issuer of a Medicare supplement policy or certificate must comply with subparagraphs (A) and (B) of this paragraph.

(A) The issuer shall not deny or condition the issuance or effectiveness of the policy or certificate including the imposition of any exclusion of

benefits under the policy based on a pre-existing condition on the basis of the genetic information with respect to such individual; and

(B) The issuer shall not discriminate in the pricing of the policy or certificate, including the adjustment of premium rates, of an individual on the basis of the genetic information with respect to such individual.

(3) Nothing in paragraph (2) of this section shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

(A) denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

(B) increasing the premium for any policy issued or issued for delivery to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy; in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group.

(4) An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

(5) Paragraph (4) of this section shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment, as defined for the purposes of applying the regulations promulgated under part C of Title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be

revised from time to time. The payment must be consistent with paragraph (2) of this section.

(6) In implementing paragraph (5) of this section, an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

(7) Notwithstanding paragraph (4) of this section, an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the conditions specified in subparagraphs (A) – (E) of this paragraph is met:

(A) the request is made pursuant to research that complies with part 46 of Title 45, Code of Federal Regulations, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research;

(B) the issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

(i) compliance with the request is voluntary; and

(ii) non-compliance will have no effect on enrollment status or premium or contribution amounts;

(C) no genetic information collected or acquired under this subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate;

(D) the issuer notifies the commissioner in writing that the issuer is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted; and

(E) the issuer complies with such other conditions as the commissioner may by rule require for activities conducted under this paragraph.

(8) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

(9) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

(10) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of paragraph (9) of this section if such request, requirement, or purchase is not in violation of paragraph (8) of this section.

CERTIFICATION. This agency hereby certifies that the adopted amendments to §§3.3303, 3.3306, 3.3308, 3.3319, and 3.3322 and new §3.3326 have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on _____, 2009.

_____
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that amendments to §§3.3303, 3.3306, 3.3308, 3.3319, and 3.3322 and new §3.3326 specified herein, concerning minimum standards for Medicare supplement policies issued or issued for delivery in this state, are adopted.

AND IT IS SO ORDERED.

_____
MIKE GEESLIN
COMMISSIONER OF INSURANCE

ATTEST:

_____
Gene C. Jarmon
General Counsel and Chief Clerk
COMMISSIONER'S ORDER NO._____