

**Subchapter T. Minimum Standards for Medicare Supplement Policies**  
**28 TAC §§3.3309, 3.3312, and 3.3324**

**TEXT.**

**§3.3309. Requirements for Application Forms and Replacement Coverage.**

(a) Application forms must [~~shall~~] include the following information, statements, and questions designed to elicit information as to whether, as of the date of the application, the applicant currently has another Medicare supplement, Medicare Advantage, Medicaid coverage, or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate currently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used.

(1) The information must [~~shall~~] be provided to prospective covered persons in statement form conforming to subparagraphs (A) - (F) of this paragraph.

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

(B) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.

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

(D) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within

90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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

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

(2) Information must [~~shall~~] be elicited from prospective covered persons by asking the following questions [~~as follows~~]: If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain

rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS. Please mark Yes or No below with an "X" to the best of your knowledge.

(A) Did you turn age 65 in the last 6 months? Yes\_\_\_ No\_\_\_

(B) Did you enroll in Medicare Part B in the last 6 months? Yes\_\_\_

No\_\_\_

(C) If yes, what is the effective date?

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

(i) {NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.} Yes\_\_\_ No\_\_\_

(ii) If yes;

(I) Will Medicaid pay your premiums for this Medicare supplement policy? Yes\_\_\_ No\_\_\_

(II) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes\_\_\_ No\_\_\_

(E) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START \_\_/\_\_/\_\_ END \_\_/\_\_/\_\_

(i) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes\_\_\_ No\_\_\_

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

Yes\_\_\_ No\_\_\_

(iii) Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes\_\_\_ No\_\_\_

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

Yes\_\_\_ No\_\_\_

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

(ii) If so, do you intend to replace your current Medicare supplement policy with this policy? Yes\_\_\_ No\_\_\_

(G) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) Yes\_\_\_ No\_\_\_

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

(ii) What are your dates of coverage under the other policy?

START \_\_/\_\_/\_\_ END \_\_/\_\_/\_\_ (If you are still covered under the other policy, leave "END" blank.)

(b) Application forms must [~~shall~~] include questions to elicit information as to whether the applicant qualifies under Insurance Code §1652.059, concerning Coverage for Certain Individuals Younger than 65, is an eligible person as defined in §3.3312(b) of this title (relating to Guaranteed Issue for Eligible Persons; Notice Requirements), or whether the applicant is eligible for reduction of any applicable preexisting condition limitation under §3.3324(c) and (d) of this title (relating to Open Enrollment).

(c) Agents must [~~shall~~] list the following:

(1) any other health insurance policies or coverages sold to the applicant that [~~which~~] are still in force; and

(2) any other health insurance policies or coverages sold to the applicant in the past five years ~~that~~ ~~[which]~~ are no longer in force.

(d) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant~~[,]~~ and acknowledged by the issuer, must ~~[shall]~~ be returned to the applicant by the issuer upon delivery of the policy.

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

(f) The notice required by subsection (e) of this section must ~~[shall]~~ be provided in substantially the following form and must ~~[shall]~~ be in a typeface no smaller than 12-point type.

Figure: 28 TAC §3.3309(f)

(g) The items found in (1) and (2) of Figure: 28 TAC §3.3309(f) apply to preexisting condition limitations and ~~[Subsection (f)(1) and (2) of this section (applicable to preexisting conditions)]~~ may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

### **§3.3312. Guaranteed Issue for Eligible Persons; Notice Requirements.**

(a) Guaranteed issue.

(1) Eligible persons are those individuals described in subsection (b) of this section who seek to enroll under the Medicare supplement policy during the period specified in subsection (d) of this section, who indicate on the application for a Medicare supplement policy that they meet the requirements of this section, and who submit evidence of eligibility as necessary, such as the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer must not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (c) of this section that is offered and is available for issuance to newly enrolled individuals by the issuer, and must not discriminate in the pricing of a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and must not impose an exclusion of benefits based on a preexisting condition under a Medicare supplement policy.

(b) Eligible persons. An eligible person is an individual described in any of the following paragraphs:

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

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under §1894 of the Social Security Act, and there are circumstances similar to the following that would permit

discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare Advantage plan:

(A) the certification of the organization or plan has been terminated;

[øf]

(B) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

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

(D) the individual demonstrates, according to [~~in accordance with~~] guidelines established by the Secretary, that:

(i) the organization offering the plan substantially violated a material provision of the organization's contract under 42 U.S.C. Chapter 7, Subchapter XVIII, Part D, in relation to the individual, including the failure to provide an individual on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide the covered care according to [~~in accord with~~] applicable quality standards; or

(ii) the organization, [øf] agent, or other entity acting on the organization's behalf[,] materially misrepresented the plan's provisions in marketing the plan to the individual; or

(E) the individual meets other exceptional conditions as the Secretary may provide.

(3) The individual is enrolled with an entity listed in subparagraphs (A) - (D) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) of this subsection:

(A) an eligible organization under a contract under §1876 of the Social Security Act (Medicare cost);

(B) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

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

(D) an organization under a Medicare Select policy.~~[-and]~~

(4) The ~~the~~ individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(A) of the insolvency of the issuer or bankruptcy of the nonissuer organization; or of other involuntary termination of coverage or enrollment under the policy;

(B) the issuer of the policy substantially violated a material provision of the policy; or

(C) the issuer, an agent, or other entity acting on the issuer's behalf~~[-]~~ materially misrepresented the policy's provisions in marketing the policy to the individual.~~[-]~~

(5) The ~~the~~ individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under §1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE

provider under §1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of the subsequent enrollment (during which time the individual is permitted to terminate the subsequent enrollment under §1851(e) of the Social Security Act). ~~[-or-]~~

(6) The ~~[the]~~ individual, on first becoming enrolled in Medicare Part B ~~[for benefits at age 65 or older]~~, enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under §1894 of the Social Security Act, and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.

(7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs, and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (c)(4) of this section.

(8) The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

(9) The individual is enrolled in a Medicare supplement plan that was issued with an effective date on or after June 1, 2010, and has had his or her current coverage in place for at least nine months. ~~[The individual meets the following requirements:]~~

~~[(A) the individual was enrolled in both the federal Medicare program and the Texas Health Insurance Pool on December 31, 2013; and]~~

~~[(B) the individual's Pool coverage terminated on or after December 31, 2013.]~~

(10) The individual meets the criteria in Insurance Code §1652.059, concerning Coverage for Certain Individuals Younger than 65, and enrolled in Medicare Part B before the effective date of this section.

(c) Products ~~that [to which]~~ eligible persons are entitled to.

(1) Persons described by subsection (b)(1), (2), (3), (4), and (8), ~~and (9)~~ of this section are entitled to a Medicare supplement policy that has a benefit package classified as follows:

(A) Plan A, B, C, D, F (including F with a High Deductible), G (including G with a High Deductible), K, or L offered by any issuer, for an individual 65 years of age or older, or an individual who meets the criteria in Insurance Code §1652.059, who first became eligible for Medicare before January 1, 2020, except that for persons under 65 years of age who do not meet the criteria in Insurance Code §1652.059, it is a policy that has a benefit package classified as Plan A; or

(B) Plan A, B, D, G (including G with a High Deductible), K, or L offered by any issuer, for a 2020 newly eligible individual who is 65 years of age or older or meets the criteria in Insurance Code §1652.059, except that for persons under 65 years of age who do not meet the criteria in Insurance Code §1652.059, it is a policy that has a benefit package classified as Plan A.

(2) Persons described by subsection (b)(5) of this section are entitled to the same Medicare supplement policy in which the individual was most recently enrolled, if available from the same issuer or, if not available, a policy described in paragraph (1) of this subsection. If the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, the Medicare supplement policy described in this paragraph is the policy available from the same issuer but modified to remove outpatient prescription drug coverage, or at the election of the policyholder, a policy described in paragraph (1) of this subsection.

(3) Persons described by subsection (b)(6) of this section are entitled to any Medicare supplement policy offered by any issuer, with the exception of Plans ~~[plans]~~ C or F (including F with a High Deductible) for a 2020 newly eligible individual.

(4) Persons described by subsection (b)(7) of this section are entitled to a Medicare supplement policy that has a benefit package classified as follows:

(A) Plan A, B, C, D, F (including F with a High Deductible), G (including G with a High Deductible), K, or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage, for an individual who first became eligible for Medicare before January 1, 2020; or

(B) Plan A, B, D, G (including G with a High Deductible), K, or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage, for a 2020 newly eligible individual.

(5) Persons described by subsection (b)(9) of this section are entitled to:

(A) any Medicare supplement policy that provides comparable or lesser coverage than their current coverage, as identified in Figure 28 TAC §3.3312(c)(5)(A) and available to the public:

(i) from the same issuer they are currently enrolled with or an affiliate of that issuer; or

(ii) if the individual's current issuer acquired the individual's coverage from another issuer without the signed consent of the individual, from any issuer that previously transferred the individual's coverage to his or her current or previous company without signed consent, or an affiliate of such issuer; and

Figure 28 TAC §3.3312(c)(5)(A)

<b>Existing Plan</b>	<b>Plans with comparable or lesser coverage</b>
Plan A	Plan A
Plan B	Plan A, B, C, D, K, L, M, N
Plan C	Plan A, B, C, D, K, L, M, N
Plan D	Plan A, B, C, D, K, L, M, N

Plan F	Plan A, B, C, D, F, High Deductible F, G, High Deductible G, K, L, M, or N
Plan High Deductible F	Plan High Deductible F or High Deductible G
Plan G	Plan A, B, C, D, F, High Deductible F, G, High Deductible G, K, L, M, or N
Plan High Deductible G	Plan High Deductible F or High Deductible G
Plan K	Plan A, K, L, M
Plan L	Plan A, B, C, D, K, L, M, N
Plan M	Plan A, K, L, M
Plan N	Plan A, B, C, D, K, L, M, N

(B) a rate that is, for an individual who is:

(i) 65 years or older, the lowest available rating category if the individual has the lowest rating category under his or her current plan, or the second lowest available rating category if the individual does not have the lowest rating category under his or her current plan;

(ii) under 65 years old and enrolled under Insurance Code §1652.059, a rate that is consistent with that section; and

(iii) under 65 who does not meet the criteria in Insurance Code §1652.059, a rate that is consistent with similarly situated individuals who enrolled under the plan as permitted under §3.3324 of this title (relating to Open Enrollment).

(6) Persons described by subsection (b)(10) of this section are entitled to enroll in any plan type that is offered by any issuer, provided that:

(A) an issuer is not permitted to make Plans C or F (including F with a High Deductible) available to a 2020 newly eligible individual;

(B) coverage must be issued according to terms provided in Insurance Code §1652.060, concerning Enrollment Period for Certain Individuals Younger than 65; and

(C) notwithstanding §3.3307(d) of this title (relating to Loss Ratio Standards and Refund or Credit of Premiums) and §3.3322(d) of this title (relating to Filing

and Approval of Policies, Certificates and Premium Rates; Discontinuance of Forms), an issuer may not have a separate form or rates for persons described by subsection (b)(10) of this section.

(d) Guaranteed issue time period.

(1) In the case of an individual described in subsection (b)(1) of this section:

(A) for a plan that supplements the benefits under Medicare, the guaranteed issue period begins on the later of:

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

(ii) the date the applicable coverage terminates or ceases; [~~and ends 63 days later;~~] or

(B) for a plan that is primary to the benefits under Medicare, the guaranteed issue period begins on the later of:

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

(ii) the date the applicable coverage terminates or ceases; and [~~ends 63 days later]~~

(C) the guaranteed issue period ends 63 days after the date the applicable coverage terminates or ceases.

(2) In the case of an individual described in subsection (b)(2), (3), (5), or (6) of this section whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(3) In the case of an individual described in subsection (b)(4)(A) of this section, the guaranteed issue period begins on the earlier of the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, and the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

(4) In the case of an individual described in subsection (b)(2), (4)(B) and (C), (5), or (6) of this section, who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date of disenrollment.

(5) In the case of an individual described in subsection (b)(7) of this section, the guaranteed issue period begins on the date the individual receives notice under §1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

(6) In the case of an individual described in subsection (b) of this section, but not described in paragraphs (1) - (5) of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date of disenrollment.

(7) In the case of an individual described in subsection (b)(9) of this section, the guaranteed issue period is continuous. [~~begins on the date that the individual's coverage in the Texas Health Insurance Pool terminates and ends 63 days later.~~]

(8) In the case of an individual described in subsection (b)(10) of this section, the guaranteed issue period is October 15, 2026, through March 31, 2027.

(e) Extended Medicare supplement access for interrupted trial periods.

(1) In the case of an individual described in subsection (b)(5) of this section (or deemed to be so described under this paragraph), whose enrollment with an organization or provider described in subsection (b)(5) of this section is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another organization or provider, the subsequent enrollment will be deemed to be an initial enrollment as described in subsection (b)(5) of this section.

(2) In the case of an individual described in subsection (b)(6) of this section (or deemed to be so described under this paragraph), whose enrollment with a plan or in a program described in subsection (b)(6) of this section is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another plan or program, the subsequent enrollment will be deemed to be an initial enrollment as described in subsection (b)(6) of this section.

(3) For purposes of subsection (b)(5) and (6) of this section, no enrollment of an individual with an organization or provider described in subsection (b)(5) of this section, or with a plan or in a program described in subsection (b)(6) of this section, may be deemed to be an initial enrollment under this paragraph after the two-year [~~2-year~~] period beginning on the date that [~~on which~~] the individual first enrolled with the organization, provider, plan, or program.

(f) Notification of right to change plans. An issuer that provides a notice of rate increase to an insured must at the same time provide the notice described in subsection (g) if the insured is described by subsection (b)(9) of this section and:

(1) the issuer or an affiliate offers to the public at least one plan that provides comparable or lesser coverage compared to the insured's current coverage; or

(2) the issuer acquired the insured's coverage from another issuer without the individual's signed consent.

(g) Notice requirements of right to change plans. An issuer described by subsection (f) of this section must provide notice of:

(1) the guaranteed purchase right under this section, including, if applicable, the right to purchase from unaffiliated entities that previously covered the individual;

(2) a list of each plan type that the individual is eligible to purchase under this section; and

(3) an explanation of how the individual can get more information and enroll.

(h) Notification of enrollment period for certain individuals under age 65. For an insured described by subsection (b)(10) of this section who enrolled in a Medicare supplement policy before the effective date of this section, the issuer must provide notice informing insureds of his or her right to change plans during the enrollment period provided in subsection (d)(8) of this section not earlier than September 1, 2025, and not later than October 15, 2025.

### **§3.3324. Open Enrollment.**

(a) Except as otherwise provided in this section, no [No] issuer may deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, subject an applicant to medical underwriting, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for a policy or certificate is submitted before or during the six-month period beginning with the first day of the first month in which an individual is first enrolled for benefits under Medicare Part B. No issuer may engage in a premium rating practice that results in higher premiums for any policy solely because the policy is issued under the provisions of this section. An issuer must make available [For individuals 65 years of age

~~or older when first enrolled for benefits under Medicare Part B who apply for Medicare supplement coverage under this subsection,~~] each Medicare supplement policy and certificate [~~currently available from an issuer must be made available~~] to all applicants who apply for coverage under this section without regard to age, subject to the following exceptions: [-]

(1) an issuer is not permitted to make Plans C or F (including F with a High Deductible) available to a 2020 newly eligible individual;

(2) an issuer is not permitted to make available a policy or certificate that has been discontinued under §3.3322 of this title (relating to Filing and Approval of Policies, Certificates and Premium Rates; Discontinuance of Forms); and

(3) an issuer may limit availability as permitted in subsection (b) of this section.

(b) The provisions [~~of paragraphs (1) and (2)~~] of this subsection apply to Medicare supplement issuers with respect to persons who qualify for Medicare before attaining 65 years of age.

(1) For individuals who do not qualify under Insurance Code §1652.059, concerning Coverage for Certain Individuals Younger than 65, an issuer must make available, at a minimum, Plan A of the standard Medicare supplement plans to an individual who qualifies under this subsection and may establish a separate form and rating class as permitted under §3.3322 of this title for similarly situated individuals who enroll in Plan A under this section. [An issuer must comply with the first two sentences of subsection (a) of this section with respect to a person who:]

~~[(A) qualifies for Medicare before attaining 65 years of age, who first enrolls for benefits under Medicare Part B on or after January 1, 1997, and who applies for a Medicare supplement policy or certificate during the period of eligibility described in subsection (a) of this section; or]~~

~~[(B) enrolled in Medicare Part B before attaining 65 years of age, who applies for a Medicare supplement policy or certificate upon attaining 65 years of age, during the period of eligibility described in subsection (a) of this section that would apply if the person first enrolled in Medicare Part B on attaining 65 years of age.]~~

(2) When an individual who is enrolled in a plan under this subsection reaches 65 years of age, he or she is entitled to an open enrollment period under subsection (a) of this section as if the individual enrolled in Medicare Part B on his or her 65th birthday, and the issuer must begin charging the premium rate that would apply if the individual submitted a new application under subsection (a) of this section. [An issuer must make available, at a minimum, Plan A of the standard Medicare supplement plans to individuals who qualify under this subsection.]

(3) An issuer covering an individual enrolled in a plan under this subsection must give notice to the individual not earlier than the individual's 64th birthday and not later than the individual's 65th birthday of the adjustment to the premium and the new open enrollment period required by this section.

(4) The provisions of this paragraph apply to individuals who qualify under Insurance Code §1652.059.

(A) For standardized Medicare supplement Plans A, B, and D, the issuer must charge a qualifying individual the same premium rate that is charged to an individual 65 years of age for the same plan, at the time of issuance and for the duration that the individual enrolled in the plan is under 65 years of age.

(B) For standardized Medicare supplement plans other than Plans A, B, or D, the issuer must charge a qualifying individual a premium rate that is no higher than 200% of the rate charged to an individual 65 years of age for the same plan, at the time of issuance and for the duration that the individual enrolled in the plan is under 65 years of age.

(C) Notwithstanding subsections (c) or (d) of this section, an issuer may not apply a preexisting condition exclusion or a waiting period to a qualifying individual.

(5) An issuer filing for a rate increase applicable to a Medicare supplement policy on or before January 1, 2028, in which the rate increase relies on actual or expected experience resulting from the implementation of Insurance Code §1652.059 or §1652.060, concerning Enrollment Period for Certain Individuals Younger than 65, must include in such filing a statement signed by an actuary as to whether the rates for those insureds under 65 years of age not qualifying under Insurance Code §1652.059 or §1652.060 satisfy the requirements of §3.3307 of this title (relating to Loss Ratio Standards and Refund or Credit of Premiums).

(c) If an applicant qualifies under subsection (a) of this section, is 65 years of age or older, and submits an application during the period referenced in subsection (a) of this section and, as of the date of application, has had a continuous period of creditable coverage:

(1) [~~has had a continuous period of creditable coverage~~] of at least six months, the issuer may not exclude benefits based on a preexisting condition; or

(2) [~~has had a continuous period of creditable coverage~~] that is less than six months, the issuer must reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date.

(d) Except as provided in subsection (c) of this section, §3.3312 of this title (relating to Guaranteed Issue for Eligible Persons; Notice Requirements), and §3.3306(b)(1)(A) of this title (relating to Minimum Benefit Standards), subsection (a) of this section may not be construed as preventing the exclusion of benefits under a policy during the first six months based on a preexisting condition for which the policyholder or certificate holder

received treatment or was otherwise diagnosed during the six months before the coverage became effective.

(e) The following examples illustrate the application of subsection (c)(1) and (2) of this section, as prescribed by the Secretary:

(1) Individual A--["] No preexisting condition exclusion period. Relevant creditable coverage history: Individual A had coverage under an individual policy for four months beginning on May 1, 1998, through August 31, 1998, followed by a gap in coverage of 61 days until October 31, 1998. Individual A had coverage under an individual health plan beginning on November 1, 1998, for three months through January 31, 1999, followed by a gap in coverage of 59 days or until March 31, 1999, on which date Individual A submitted an application for a Medicare supplement policy. Under this example, the Medicare supplement issuer may not apply a preexisting condition exclusion period because Individual A has seven months of creditable coverage without a gap in coverage greater than 63 days.

(2) Individual B--["] Subject to a three-month preexisting condition exclusion period. Relevant creditable coverage history: Individual B is covered under an individual health insurance policy for one month beginning May 1, 1998, through May 31, 1998, followed by a gap in coverage of 61 days from June 1, 1998, through July 31, 1998. On August 1, 1998, Individual B is covered under an association health plan for two months through September 30, 1998, followed by a gap in coverage of 31 days or until October 31, 1998, on which date Individual B submitted an application for Medicare supplement coverage. Individual B has three months of creditable coverage. Under this example, the issuer of a Medicare supplement policy must give Individual B a three-month credit against any preexisting condition exclusion period.

(3) Individual C--["] Subject to a six-month preexisting condition exclusion period. Relevant creditable coverage history: Individual C is covered under an individual

health insurance policy for one month beginning May 1, 1998, through May 31, 1998, followed by a gap in coverage of 61 days from June 1, 1998, through July 31, 1998. On August 1, 1998, Individual C is covered under an association health plan for two months through September 30, 1998, followed by a gap in coverage of 64 days or until November 4, 1998, on which date Individual C submitted an application for Medicare supplement coverage. Individual C has a gap in coverage of greater than 63 days. As a result, under this example, the Medicare supplement issuer can fully apply the preexisting condition exclusion provision to Individual C.

(f) Invitation to contract advertisements, as defined in §21.113(b) of this title (relating to Rules Pertaining Specifically to Accident and Health Insurance Advertising and Health Maintenance Organization Advertising), must include the following statement: "Benefits and premiums under this policy may be suspended for up to 24 months if you become entitled to benefits under Medicaid. You must request that your policy be suspended within 90 days of becoming entitled to Medicaid. If you lose (are no longer entitled to) benefits from Medicaid, this policy can be reinstated if you request reinstatement within 90 days of the loss of such benefits and pay the required premium."