currently implemented or the way the Rule has been implemented in the past. The amendment to §1705 will allow a licensed practical nurse, who is working in Louisiana on an emergency temporary permit during a declared state of public health emergency, to receive a wage for nursing services rendered. This change is in order to help employers attract sufficient numbers of licensed practical nurse volunteers to work in Louisiana during a declared state of public health emergency.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part XLVII. Nurses: Practical Nurses and Registered Nurses

Subpart 1. Practical Nurses

Chapter 3. Board of Practical Nurse Examiners

§306. Adjudication Proceedings

A. - D. ...

E. Unless precluded by law, informal disposition may be made of any case of adjudication by stipulation, agreed settlement, consent order, or default. A consent order or agreed settlement shall be presented to the board for approval before it becomes binding on the board.

F. - O. ...

P. After the hearing is concluded, the hearing officer shall issue a report containing his/her findings of fact, conclusions of law and recommendations. This report shall be presented to the board in executive session and shall be considered privileged and confidential until and unless it is adopted in final form by the board.

Q. - U. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:969 and 37:978 and Acts 675 and 827, 1993.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, LR 2:275 (September 1976), amended LR 3:193 (April 1977), LR 10:336 (April 1984), amended by the Department of Health and Hospitals, Board of Practical Nurse Examiners, LR 18:1126 (October 1992), repromulgated LR 18:1259 (November 1992), amended LR 20:663 (June 1994), LR 26:2614 (November 2000), LR 28:2353 (November 2002), LR 30:1478 (July 2004), LR 34:1912 (September 2008), LR 35:1247 (July 2009).

Chapter 17. Licensure

§1705. Temporary Permit

A. - C. ...

D. During a declared state of public health emergency, an emergency temporary permit may be issued to practical nurses licensed in another jurisdiction of the U.S. whose license is current, unrestricted and in good standing in such jurisdiction, provided that the practical nurse register with the board prior to providing practical nursing care. The emergency permit may be issued for 60 days or until termination of the state of public health emergency, whichever comes first. The permit may be extended for two additional 60 day periods.

E. - F. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:969 and 37:976.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Practical Nurse Examiners, LR 3:200 (April 1977), amended LR 10:341 (April 1984), amended by the Department of Health and Hospitals, Board of Practical Nurse Examiners, LR 18:1130 (October 1992), repromulgated LR 18:1263 (November 1992), amended LR 28:2355 (November 2002), LR 32:637 (April 2006), LR 33:93 (January 2007), amended LR 35:1247 (July 2009).

Claire Doody Glaviano
Executive Director

0907#018

RULE

Department of Insurance
Office of the Commissioner

Regulation 33—Medicare Supplemental Insurance Minimum Standards (LAC 37:XIII.Chapter 5)

Editor's Note: Section 503 is being repromulgated because of an error. The original Rule can be viewed in its entirety on page 1114 of the June 20, 2009 *Louisiana Register*.

The Department of Insurance, pursuant to the authority of the Louisiana Insurance Code, R.S. 22:1 et seq., and in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., has amended Regulation 33 regarding Medicare Supplemental Insurance Minimum Standards.

The National Association for Insurance Commissioners (NAIC) recently amended the NAIC model regulation on Medicare Supplemental Insurance Minimum Standards to reflect changes made under the Genetic Information Nondiscrimination Act (GINA) and the Medicare Improvement for Patients and Providers Act (MIPPA), and the Louisiana Department of Insurance is adopting these changes which affect the following Sections: LAC 37:XIII §503, §505, §510, §515, §516, §520, §521, §525, §535, §560, and §591. Sections 516, 521, and 591 are additions to the proposed regulation. Section 507 is repealed in its entirety.

Non-substantive language has been added to Sections 503, 515, 516, 520, 521, and 560 to clarify references to policies "issued for delivery on or after June 1, 2010." These technical clarifications are intended to permit the sale of Medicare policies with new benefit packages prior to June 1, 2010 provided such policies have an effective date on or after June 1, 2010. NAIC recently notified state regulators that the intent of these technical changes comports with federal law and such changes were inadvertently omitted from revisions made to the final NAIC Medicare Supplement Insurance Minimum Standards Model Act prior to its adoption. The department is hereby adopting these technical changes accordingly.

Title 37

INSURANCE

Part XIII. Regulations

Chapter 5. Regulation 33—Medicare Supplement Insurance Minimum Standards

§503. Definitions

A. ...

* * *

Commissioner—the Commissioner of Insurance of the state of Louisiana.

* * *

Issuer—insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity authorized to deliver or issue for delivery in this state Medicare supplement policies or

certificates. For purposes of §591.A.10.a. of this regulation, the term shall also include third party administrators, or any other person acting for or on behalf of such issuer.

* * *

Pre-Standardized Medicare Supplement Benefit Plan, Pre-Standardized Benefit Plan or Pre-Standardized Plan—a group or individual policy of Medicare supplement insurance issued prior to July 20, 1992.

1990 Standardized Medicare Supplement Benefit Plan, 1990 Standardized Benefit Plan or 1990 Plan—a group or individual policy of Medicare supplement insurance issued on or after July 20, 1992 and with an effective date for coverage prior to June 1, 2010 and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

2010 Standardized Medicare Supplement Benefit Plan, 2010 Standardized Benefit Plan or 2010 Plan—a group or individual policy of Medicare supplement insurance issued with an effective date for coverage on or after June 1, 2010.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1111 (re-designated from R.S. 22:224 pursuant to Acts 2008, No. 415, effective January 1, 2009) and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1102 (June 1999), repromulgated LR 25:1481 (August 1999), amended LR 29:2435 (November 2003), LR 31:2902 (November 2005), LR 35:1114 (June 2009), repromulgated LR 35:1247 (July 2009).

James J. Donelon
Commissioner

0907#019

RULE

Department of Public Safety and Corrections
Corrections Services

Offender Visitation (LAC 22:I.316)

In accordance with the provisions of the Administrative Procedures Act (R.S. 49:950), the Department of Public Safety and Corrections, Corrections Services, has amended the contents of §316, Offender Visitation.

Title 22
CORRECTIONS, CRIMINAL JUSTICE AND LAW ENFORCEMENT
Part I. Corrections
Chapter 3. Adult Services
Subchapter A. General
§316. Offender Visitation

A. Purpose. To establish the secretary's policy regarding offender visitation and to set forth the procedures to be followed concerning offender visitation.

B. Applicability. Deputy Secretary, Chief of Operations, Assistant Secretary, Regional Wardens and Wardens. Each warden is responsible for ensuring that appropriate unit written policy and procedures are in place to comply with the provisions of this regulation and for conveying its content to all offenders, affected employees and visitors.

C. Policy. The department recognizes the importance of visitation in the maintenance of an offender's family ties; visitation is an integral component of institutional management. Visiting can improve public safety and encourage offender accountability. Authorized visitation is permitted by the department to facilitate an offender's institutional adjustment in accordance with the department's goals and mission. The visiting process shall be conducted in an atmosphere that is conducive for the safe, secure and orderly management and operation of the institution. Thus, the visiting process will not overly tax the institution's resources or its ability to maintain adequate control and supervision. In this matter, as in all others affecting institutional operations, safety and security are primary considerations.

1. Each warden shall be responsible for ensuring written information regarding visiting procedures is made available to offenders within 24 hours following the offender's arrival at the institution. At a minimum, the information shall include, but is not limited to, the following: address and phone number of the institution; directions to the institution; information regarding local transportation; days and hours of visitation; approved dress code; identification requirements; authorized items; rules for children and special visits.

D. Definitions

Attorney Visit—visit by an attorney or authorized representative, such as a paralegal assistant, law clerk and investigator whose credentials have been verified.

Disrespect—hostile, sexual, abusive, threatening language or gestures, verbal or written, towards or about another person by a visitor.

Disturbance—conduct or activity which unnecessarily interferes with visitation operations, and/or which advocates, encourages, promotes or otherwise creates or poses a threat to the safety, security, health and good order of the institution, and/or the safety and security of offenders, staff or visitors. A visitor commits a disturbance if the visitor advocates, creates, engages in, maintains or promotes an annoying condition or disorder characterized by unruly, noisy or violent conduct.

Employee—any person employed full-time, part-time or on temporary appointment by the department.

Excessive Contact—prolonged or frequent contact between a visitor and an offender that exceeds the brief embrace and kiss upon meeting and leaving and hand-holding. Excessive is not casual contact, but rather a pattern of contact beyond rule limits.

Family Member—includes the offender's identifiable parents, siblings, children, legal spouse, aunts, uncles, nieces, nephews, grandchildren and grandparents, including foster, in-law, and step-relationships or any others indicated on the offender's master prison record as having raised the offender.

Immediate Family Member—includes the offender's identifiable parents, siblings, children, legal spouse and any others indicated on the offender's master prison record as having raised the offender.

Intake Status—the 30-day period of time following delivery of an offender to the custody of the department. During this time, staff conducts intake processing of the offender including, but not limited to, medical and mental health assessments, custody classification and identification of programming needs and assignments.

of 6 graduate courses in marriage and family therapy including coursework on the AAMFT Code of Ethics and a minimum of 500 supervised direct client contact hours, with a minimum of 250 hours of these 500 hours with couples and families, and a minimum of 100 hours of face-to-face supervision. The training of the supervisor must be equivalent to that of an AAMFT Approved Supervisor or AAMFT Supervisor Candidate.

B. - C.2.iii. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1101-1122.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Licensed Professional Counselors Board of Examiners, LR 29:156 (February 2003), amended LR 29:2785 (December 2003), LR 35:1113 (June 2009).

§3313. Examination Requirements

A. The examination for licensure shall be the national marriage and family therapy examination as determined by the advisory committee. No other examination will be accepted.

B. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1101-1122.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Licensed Professional Counselors Board of Examiners, LR 29:158 (February 2003), amended LR 35:1114 (June 2009).

§3315. Supervision Requirements

A. General Provisions

1. Applicants who meet the degree or certification requirements must successfully complete a minimum of two years of work experience in marriage and family therapy under qualified supervision in accordance with COAMFTE supervision standards as described in this Section.

B. Definitions for Supervision

***

MFT Intern—a person registered with the board who is receiving supervision from an LMFT-approved supervisor or LMFT-registered supervisor candidate.

***

C. Supervision Requirements for Licensure

1. A registered MFT intern must complete a minimum of two years of post-graduate work experience in marriage and family therapy that includes at least 3,000 hours of clinical services to individuals, couples, or families.

1.a. - 7.e. ...

D. Qualifications of an LMFT-Approved Supervisor and an LMFT-Registered Supervisor Candidate

1. - 2. ...

3. A person who wishes to become an LMFT-approved supervisor must be a licensed marriage and family therapist and must submit a completed application that documents that he or she meets the requirements. in one of two ways.

a. The applicant may meet the requirements by meeting the following coursework, experience, and supervision of supervision requirements.

i. Coursework requirements:

(a). a one-semester graduate course in marriage and family therapy supervision from a regionally accredited institution; or

(b). an equivalent course of study consisting of a 15-hour didactic component and a 15-hour interactive component in the study of marriage and family therapy supervision approved by the advisory committee. The interactive component must include a minimum of four persons.

ii. Experience requirements:

(a). has a minimum of two years experience as a licensed marriage and family therapist.

iii. Supervision of Supervision requirements:

(a). Thirty-six hours of supervision of supervision for marriage and family therapy must be taken from an LMFT-approved supervisor.

(b). - (c). Repealed

b. ...

4. LMFT-registered Supervisor Candidate

a. ...

i. includes documentation of a minimum of two years of experience as a licensed marriage and family therapist;

a.ii. - d. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1101-1122.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Licensed Professional Counselors Board of Examiners, LR 29:158 (February 2003), amended LR 29:2787 (December 2003), LR 35:1114 (June 2009).

Gloria Bockrath
Chairman

0906#046

RULE

Department of Insurance
Office of the Commissioner

Regulation 33—Medicare Supplemental Insurance Minimum Standards (LAC 37:XIII.Chapter 5)

The Department of Insurance, pursuant to the authority of the Louisiana Insurance Code, R.S. 22:1 et seq., and in accordance with the Administrative Procedure Act, R.S. 49:950, et seq., has amended Regulation 33 regarding Medicare Supplemental Insurance Minimum Standards.

The National Association for Insurance Commissioners (NAIC) recently amended the NAIC model regulation on Medicare Supplemental Insurance Minimum Standards to reflect changes made under the Genetic Information Nondiscrimination Act (GINA) and the Medicare Improvement for Patients and Providers Act (MIPPA), and the Louisiana Department of Insurance is adopting these changes which affect the following Sections: LAC 37:XIII §503, §505, §510, §515, §516, §520, §521, §525, §535, §560, and §591. Sections 516, 521, and 591 are additions to the proposed regulation. Section 507 is repealed in its entirety.

Non-substantive language has been added to Sections 503, 515, 516, 520, 521, and 560 to clarify references to policies "issued for delivery on or after June 1, 2010." These technical clarifications are intended to permit the sale of Medicare policies with new benefit packages prior to June 1, 2010 provided such policies have an effective date on or after June 1, 2010. NAIC recently notified state regulators that the intent of these technical changes comports with

federal law and such changes were inadvertently omitted from revisions made to the final NAIC Medicare Supplement Insurance Minimum Standards Model Act prior to its adoption. The department is hereby adopting these technical changes accordingly.

Title 37

INSURANCE

Part XIII. Regulations

Chapter 5. Regulation 33—Medicare Supplement Insurance Minimum Standards

§503. Definitions

A. ...

* * *

Commissioner—the Commissioner of Insurance of the state of Louisiana.

* * *

Issuer—insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity authorized to deliver or issue for delivery in this state Medicare supplement policies or certificates. For purposes of §591.A.10.a. of this regulation, the term shall also include third party administrators, or any other person acting for or on behalf of such issuer.

* * *

Pre-Standardized Medicare supplement benefit Plan, Pre-Standardized benefit Plan or Pre-Standardized Plan—a group or individual policy of Medicare supplement insurance issued prior to July 20, 1992.

1990 Standardized Medicare supplement benefit plan, 1990 Standardized benefit Plan or 1990 plan—a group or individual policy of Medicare supplement insurance issued on or after July 20, 1992 and with an effective date for coverage prior to June 1, 2010 and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

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

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1111 (re-designated from LSA-R.S. 22:224 pursuant to Acts 2008, No. 415, effective January 1, 2009) and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1102 (June 1999), repromulgated LR 25:1481 (August 1999), amended LR 29:2435 (November 2003), LR 31:2902 (November 2005), LR 35:1115 (June 2009).

§505. Policy Provisions

A. Except for permitted preexisting condition clauses as described in §510.A.1.a, §515.A.1.a, and §516.A.1.a of this regulation, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

B. - C. ...

D.1. Subject to §§510.A.1(d), (e), and (g), and 515.A.1(d) and (e) of this regulation, a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

2. - 3.b. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1111 (re-designated from LSA-R.S. 22:224 pursuant to Acts 2008, No. 415, effective January 1, 2009) and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1102 (June 1999), repromulgated LR 25:1483 (August 1999), LR 29:2436 (November 2003), amended LR 31:2904 (November 2005), LR 35:1115 (June 2009).

§506. Premium Increase Requirements

A. ...

B. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate stating in substance that the policyholder or certificateholder will be notified at least 45 days before any premium increase.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1111 (re-designated from LSA-R.S. 22:224 pursuant to Acts 2008, No. 415, effective January 1, 2009) and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 29:2437 (November 2003), repromulgated LR 31:2904 (November 2005), amended LR 35:1115 (June 2009).

§507. Rate Increases Requirements

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1111 (re-designated from LSA-R.S. 22:224 pursuant to Acts 2008, No. 415, effective January 1, 2009) and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 29:2437 (November 2003), repromulgated LR 31:2904 (November 2005), repealed LR 35:1115 (June 2009).

§510. Minimum Benefit Standards for Pre-Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery Prior to July 20, 1992

A. - A.1.b. ...

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. - e.ii.(a)....

(b). an individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in §516.A.2 of this regulation;

1.e.ii.(c). - 2.g. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1111 (re-designated from LSA-R.S. 22:224 pursuant to Acts 2008, No. 415, effective January 1, 2009) and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1103 (June 1999), repromulgated LR 25:1483 (August 1999), amended LR 29:2437 (November 2003), LR 31:2905 (November 2005), LR 35:1115 (June 2009).

§515. Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After July 20, 1992 and with an Effective Date for Coverage Prior to June 1, 2010

A. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 20, 1992 and with an effective date for coverage prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

1. - 1.b ...

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, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

d.-g.iv.(c). ...

h.i. If an issuer makes a written offer to the Medicare Supplement policyholders or certificateholders of one or more of its plans, to exchange during a specified period from his or her 1990 Standardized plan (as described in §520 of this regulation) to a 2010 Standardized plan (as described in §521 of this regulation), the offer and subsequent exchange shall comply with the following requirements:

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

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

iv. An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six months to any added benefits contained in the new 2010 Standardized policy or certificate not contained in the exchanged policy.

v. The new policy or certificate shall be offered to all policyholders or certificateholders within a given plan, except where the offer or issue would be in violation of state or federal law.

2. - 5.c....

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1111 (re-designated from LSA-R.S. 22:224 pursuant to Acts 2008, No. 415, effective January 1, 2009) and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1104 (June 1999), repromulgated LR 25:1484 (August 1999), amended LR 29:2438 (November 2003), LR 31:2906 (November 2005), LR 35:1116 (June 2009).

§516. Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date For Coverage on or After June 1, 2010

A. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer 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 with an effective date for coverage prior to June 1, 2010 remain subject to the requirements of §510, §515, §520, and §525.

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

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.

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, co-payment, 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.

e. Each Medicare supplement policy shall be guaranteed renewable.

i. The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.

ii. The issuer shall not cancel or non-renew 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 under §516.A.1.e.v. of this regulation, the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):

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

(b). provides for benefits that otherwise meet the requirements of this Subsection.

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

(a). offer the certificateholder the conversion opportunity described in §516.A.1.e.iii. of this regulation; or

(b). at the option of the group policyholder, offer the certificateholder 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 will not be considered in determining a continuous loss.

g.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 certificateholder for the period (not to exceed 24 months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to assistance.

ii. If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within ninety (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 if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss.

iv. Reinstitution of coverages as described in Subparagraphs (ii) and (iii):

(a). shall not provide for any waiting period with respect to treatment of preexisting conditions;

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

(c). shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder 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.

a. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first through the ninetieth 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 3 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. Hospice Care: 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 §521 of this regulation.

a. Medicare Part A Deductible: Coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period.

b. Medicare Part A Deductible: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period.

c. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

d. Medicare Part B Deductible: Coverage for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

e. 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.

f. 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1111 (re-designated from LSA-R.S. 22:224 pursuant to Acts 2008, No. 415, effective January 1, 2009) and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 35:1116 (June 2009).

§520. Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After July 20, 1992 and with an Effective Date for Coverage Prior to June 1, 2010

Editor's Note: This Section is being repromulgated to change the Section name only.

A. - G. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1106 (June 1999), repromulgated LR 25:1487 (August 1999), LR 29:2440 (November 2003), amended LR 31:2909 (November 2005), repromulgated LR 35:1118 (June 2009).

§521. Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or After June 1, 2010

A. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage before June 1, 2010 remain subject to the requirements of §510, §515, §520, and §525.

1.a. An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic (core) benefits, as defined in §516.A.2 of this regulation.

b. If an issuer makes available any of the additional benefits described in §516.A.3, or offers standardized benefit Plans K or L (as described §521.A.5.h and i of this regulation), then the issuer shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic (core) benefits as described in Subsection A.1.a. above, a policy form or certificate form containing either standardized benefit Plan C (as described in §521.A.5.c. of this regulation) or standardized benefit Plan F (as described in §521.A.5.e. of this regulation).

2. No groups, packages or combinations of Medicare supplement benefits other than those listed in this Section shall be offered for sale in this state, except as may be permitted in §521.A.6. and in §525 of this regulation.

3. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this Subsection and conform to the definitions in §503 of this regulation. Each benefit shall be structured in accordance with the format provided in §516.A.2 and §516.A.3 of this regulation; or, in the case of plans K or L, in §521.A.5.h or i of this regulation and list the benefits in the order shown. For purposes of this Section, "structure, language, and format" means style, arrangement and overall content of a benefit.

4. In addition to the benefit plan designations required in §521.A.3 of this Section, an issuer may use other designations to the extent permitted by law.

5. Make-up of 2010 Standardized Benefit Plans:

a. Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in §516.A.2. of this regulation.

b. Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in §516.A.2. of this regulation, plus 100 percent of the Medicare Part A deductible as defined in §516.A.3.a. of this regulation.

c. Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in §516.A.2. of this regulation, 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 §516.A.3.a, c, d, and f of this regulation, respectively.

d. Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit (as defined in §516.A.2 of this regulation), 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 §516.A.3.a, c, and f of this regulation, respectively.

e. Standardized Medicare supplement regular Plan F shall include only the following: The basic (core) benefit

as defined in §516.A.2 of this regulation, 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 §516.A.3.a, c, d, e, and f, respectively.

f. Standardized Medicare supplement Plan F With High Deductible shall include only the following: 100 percent of covered expenses following the payment of the annual deductible set forth in Subparagraph ii.

i. The basic (core) benefit as defined in §516.A.2 of this regulation, 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 §516.A.3.a, c, d, e, and f of this regulation, 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 from 1999 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) benefit as defined in §516.A.2 of this regulation, 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 §516.A.3.a, c, e, and f, 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 Sixty-first through the Ninetieth Day: Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

ii. Part A Hospital Coinsurance, Ninety-first through the One Hundredth Fiftieth Day: Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

iii. Part A Hospitalization After One Hundred Fifty 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 Subparagraph x.;

v. Skilled Nursing Facility Care: Coverage for 50 percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth 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 Subparagraph x.;

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 Subparagraph x.;

vii. Blood: Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph x.;

viii. Part B Cost Sharing: Except for coverage provided in Subparagraph (ix), 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 Subparagraph x.;

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 Paragraphs §521.A.5.h.i., ii, iii and ix;

ii. the benefits described in Paragraphs §521.A.5.h.iv., v, vi, vii and viii, but substituting 75 percent for 50 percent; and

iii. the benefit described in Paragraph §521.A.5.h.x, but substituting $2000 for $4000.

j. Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in §516.A.2 of this regulation, 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 §516.A.3.b, c and f of this regulation, respectively.

k. Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in §516.A.2 of this regulation, 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 §516.A.3.a, c and f. of this regulation, respectively, with co-payments in the following amounts:

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

ii. the lesser of $50 or the Medicare Part B coinsurance or co-payment 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. New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits, in addition to the 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1111 (re-designated from LSA-R.S. 22:224 pursuant to Acts 2008, No. 415, effective January 1, 2009) and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR:35:1118 (June 2009).

§525. Medicare Select Policies and Certificates

A.1. - E.1.b.ii. ...

c. there are written agreements and/or contracts with network providers describing specific responsibilities;

d. ...

e. in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements and/or contracts with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare select policy or certificate. This Paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare select policy or certificate;

2. ...

3. a detailed description and the method utilized by the Medicare select insurer of informing policyholders of the plan's service and features, including but not limited to, the plan's grievance procedures, its process for choosing and changing in-network providers, and the procedures for providing and approving emergency and specialty care;

4. - 4.c. ...

5. a list and description, by specialty, of the network providers, including the Medicare select issuer's procedures for making referrals within and outside its network;

6. ...

7. the listing of hospitals and the number of hospital beds available for the policyholders at an in-network hospital;

8. any other information requested by the commissioner.

F.1. A Medicare select issuer shall file for approval any proposed changes, material or otherwise, to the plan of operation or contracts, except for changes to the listing of network providers, with the commissioner prior to implementation of any changes. The removal or withdrawal of any hospital from a Medicare select issuer's network shall constitute a material change to the plan of operation or contract and shall be filed with the commissioner in accordance with the provisions of this Subsection. Changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

2. All filings of proposed changes, material or otherwise, to the plan of operation or contracts as required by this Section shall include, but not be limited to the following:

a. the listing of hospitals and the number of hospital beds available for the policyholders at an in-network hospital;

b. any other information requested by the commissioner.

3. An updated list of network providers shall be filed with the commissioner at least quarterly.

G. - O. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1111 (re-designated from LSA-R.S. 22:224 pursuant to Acts 2008, No. 415, effective January 1, 2009) and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1108 (June 1999), repromulgated LR 25:1488 (August 1999), amended LR 29:2442 (November 2003), LR 31:2910 (November 2005), LR 32:1462 (August 2006), LR:35:1120 (June 2009).

§535. Guaranteed Issue for Eligible Persons

A. - B.3.a.iv. ...

b. pursuant to Subsection B.3.a.i, B.3.a.ii, and B.3.a.iii, the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under §535.B.2; or pursuant to Subsection B.3.a.iv, the enrollment ceases and discontinuance of an individual's election of coverage occurs due to one of the following:

i. the certification of the organization or plan has been terminated, or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

ii. 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 commissioner, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area;

iii. the individual demonstrates, in accordance with guidelines established by the commissioner, that:

(a). the organization offering the plan substantially violated a material provision of the organization's contract(s) or plan of operation or the organization offering the plan made a material change or altered the organization's contract(s) or plan of operation that

potentially impacts the individual under this Part or Regulation 33, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality or adequacy standards or failure to provide covered services in accordance with the plan of operation, including but not limited to the adequacy of a organization's provider network(s); or

(b). the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

B.4. - F.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1111 (re-designated from LSA-R.S. 22:224 pursuant to Acts 2008, No. 415, effective January 1, 2009) and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1110 (June 1999), repromulgated LR 25:1490 (August 1999), amended LR 29:2444 (November 2003), LR 31:2912 (November 2005), LR:35:1120 (June 2009).

§560. Required Disclosure Provisions

A. - D.3.b. ...

4. the following items shall be included in the outline of coverage in the order prescribed below:

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in Louisiana.

Plans E, H, I, and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]

Basic Benefits:

- Hospitalization – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Medical Expenses – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.
- Blood – First three pints of blood each year.
- Hospice – Part A coinsurance

A	B	C	D	F F*	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*	Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible	
				Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $[4620]; paid at 100% after limit reached	Out-of-pocket limit $[2310]; paid at 100% after limit reached		

* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

PREMIUM INFORMATION [Boldface Type]

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

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. [This paragraph shall not appear after June 1, 2011].

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

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

RIGHT TO RETURN POLICY [Boldface Type]

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

POLICY REPLACEMENT [Boldface Type]

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

NOTICE [Boldface Type]

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

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

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

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

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

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to §521.D of this regulation.] [Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

Plan A

Medicare (Part A)—Hospital Services—Per Benefit Period

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

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$0	$[1068](Part A deductible)
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
--Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care*			
You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	$0	Up to $[133.50] a day
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite Care	Medicare copayment/ Coinsurance	$0

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

Plan A

Medicare (Part B)—Medical Services—Per Calendar Year

*Once you have been billed $[135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses—In or Out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare Approved Amounts*	$0	$0	$[135](Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
Blood			
First 3 pints	$0	All Costs	$0
Next $[135] of Medicare Approved Amounts*	$0	$0	$[135](Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services—Tests for Diagnostic Services	100%	$0	$0

Parts A and B

Home Health Care Medicare Approved Services			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First $[135] of Medicare Approved Amounts*	$0	$0	$[135](Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

Plan B

Medicare (Part A)—Hospital Services—Per Benefit Period

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

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068](Part A Deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
--Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	$0	Up to $[133.50] a day
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

Plan B

Medicare (Part B)—Medical Services—Per Calendar Year

*Once you have been billed $[135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses—In or Out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare-Approved Amounts*	$0	$0	$[135] (Part B Deductible)
Remainder of Medicare- Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges			
(Above Medicare Approved Amounts)	$0	$0	All Costs
Blood			
First 3 pints	$0	All Costs	$0
Next $[135] of Medicare-Approved Amounts*	$0	$0	$[135] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services--			
Tests for Diagnostic Services	100%	$0	$0

Parts A and B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care			
Medicare Approved Services			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First $[135] of Medicare-Approved Amounts*	$0	$0	$[135] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

Plan C

Medicare (Part A)—Hospital Services—Per Benefit Period

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

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068](Part A Deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
--Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite Care	Medicare co-payment/ coinsurance	$0

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

Plan C

Medicare (Part B)—Medical Services—Per Calendar Year

*Once you have been billed $[135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses—In or Out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare-Approved Amounts*	$0	$[135] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges			
(Above Medicare Approved Amounts)	$0	$0	All Costs
Blood			
First 3 pints	$0	All Costs	$0
Next $[135] of Medicare-Approved Amounts*	$0	$[135] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services—			
Tests for Diagnostic Services	100%	$0	$0

Parts A and B

Home Health Care			
Medicare Approved Services			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First $[135] of Medicare-Approved Amounts*	$0	$[135] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

Other Benefits—Not Covered by Medicare

Foreign Travel—Not Covered By Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan D

Medicare (Part A)—Hospital Services—Per Benefit Period

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

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068](Part A Deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
--Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

Services	Medicare Pays	Plan Pays	You Pay
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

Plan D
Medicare (Part B)—Medical Services—Per Calendar Year

*Once you have been billed $[135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses—In or Out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare-Approved Amounts*	$0	$0	$[135] (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
Blood			
First 3 pints	$0	All Costs	$0
Next $[135] of Medicare-Approved Amounts*	$0	$0	$[135] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services— Tests For Diagnostic Services	100%	$0	$0

Plan D (continued)
Parts A and B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care Medicare Approved Services			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First $[135] of Medicare-Approved Amounts*	$0	$0	$[135] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

Other Benefits—Not Covered by Medicare

Foreign Travel—Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan F or High Deductible Plan F
Medicare (Part A)—Hospital Services—Per Benefit Period

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

[**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$2000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

Services	Medicare Pays	[After You Pay [$2000] Deductible,** Plan Pays]	[In Addition to [$2000] Deductible,** You Pay]
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068](Part A Deductible)	$0
61st thru 90th day	All but $ [267]a day	$[267]a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[534]a day	$[534] a day	$0
--Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

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

Plan F or High Deductible Plan F (Continued)
Medicare (Part B)—Medical Services—Per Calendar Year

*Once you have been billed $[135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

[**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$2000] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

Services	Medicare Pays	[After You Pay $2000 Deductible,** Plan Pays]	[In Addition to $2000 Deductible,** You Pay]
Medical Expenses—In or Out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare-Approved Amounts*	$0	$[135] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges			
(Above Medicare Approved Amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All Costs	$0
Next $[135] of Medicare-Approved Amounts*	$0	$[135] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services—			
Tests For Diagnostic Services	100%	$0	$0

Parts A and B

Home Health Care			
Medicare Approved Services			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First $[135] of Medicare-Approved Amounts*	$0	$[135] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

Plan F or High Deductible Plan F (Continued)

Other Benefits—Not Covered by Medicare

Services	Medicare Pays	After You Pay $2000 Deductible,** Plan Pays	In Addition to $2000 Deductible,** You Pay
Foreign Travel—Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan G

Medicare (Part A)—Hospital Services—Per Benefit Period

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

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068] (Part A Deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
--Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

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

Plan G

Medicare (Part B)—Medical Services—Per Calendar Year

*Once you have been billed $[135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses—In or Out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare-Approved Amounts*	$0	$0	$[135 (Part B Deductible)]
Remainder of Medicare-Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All Costs	$0
Next $[135] of Medicare-Approved Amounts*	$0	$0	$[135] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services— Blood Tests For Diagnostic Services	100%	$0	$0

Plan G (Continued)
Parts A and B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care Medicare Approved Services --Medically necessary skilled care services and medical supplies --Durable medical equipment First $[135] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $[135] (Part B Deductible) $0

Other Benefits—Not Covered by Medicare

Foreign Travel--Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

Plan K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[4620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare co-payment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Medicare (Part A)—Hospital Services—Per Benefit Period

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

Services	Medicare Pays	Plan Pays	You Pay*
Hospitalization** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the additional 365 days	 All but $[1068] All but $[267] a day All but $[534] a day $0 $0	 $[534](50% of Part A deductible) $[267] a day $[534] a day 100% of Medicare eligible expenses $0	 $[534](50% of Part A deductible)♦ $0 $0 $0*** All costs
Skilled Nursing Facility Care** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	 All approved amounts All but $[133.50] a day $0	 $0 Up to $[66.75] a day $0	 $0 Up to $[66.75] a day ♦ All costs
Blood First 3 pints Additional amounts	 $0 100%	 50% $0	 50%♦ $0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of co-payment/coinsurance	50% of Medicare co-payment/coinsurance♦

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

Plan K

Medicare (Part B)—Medical Services—Per Calendar Year

****Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay*
Medical Expenses—In or Out of the Hospital and Outpatient Hospital Treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare Approved Amounts****	$0	$0	$[135] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $[4620])*
Blood			
First 3 pints	$0	50%	50%♦
Next $[135] of Medicare Approved Amounts****	$0	$0	$[135] (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Clinical Laboratory Services—Tests For Diagnostic Services	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4620] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Plan K

Parts A and B

Services	Medicare Pays	Plan Pays	You Pay*
Home Health Care			
Medicare Approved Services			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $[135] of Medicare Approved Amounts*****	$0	$0	$[135] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	10%	10%♦

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

Plan L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[2310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare co-payment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Medicare (Part A)—Hospital Services—Per Benefit Period

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

Services	Medicare Pays	Plan Pays	You Pay*
Hospitalization**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[808.50] (75% of Part A deductible)	$[267] (25% of Part A deductible)♦
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare eligible expenses	$0***
--Beyond the additional 365 days	$0	$0	All costs

Services	Medicare Pays	Plan Pays	You Pay*
Skilled Nursing Facility Care**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility			
Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[100.13] a day	Up to $[33.38] a day♦
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	75%	25%♦
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of co-payment/coinsurance	25% of co-payment/coinsurance♦

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

Plan L
Medicare (Part B)—Medical Services—Per Calendar Year

****Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay*
Medical Expenses—In or Out of the Hospital and Outpatient Hospital Treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare Approved Amounts****	$0	$0	$[135] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $[2310])*
Blood			
First 3 pints	$0	75%	25%♦
Next $[135] of Medicare Approved Amounts****	$0	$0	$[135] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
Clinical Laboratory Services— Tests For Diagnostic Services	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2310] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Plan L
Parts A and B

Services	Medicare Pays	Plan Pays	You Pay*
Home Health Care			
Medicare Approved Services			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First $[135] of Medicare Approved Amounts*****	$0	$0	$[135] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	15%	5% ♦

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

Plan M
Medicare (Part A)—Hospital Services—Per Benefit Period

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

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[534] (50% of Part A deductible)	$[534] (50% of Part A deductible)
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
--Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

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

Plan M
Medicare (Part B)—Medical Services—Per Calendar Year

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses—In or Out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[135] of Medicare-Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Costs
Blood			
First 3 pints	$0	All Costs	$0
Next $[135] of Medicare-Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services—Tests For Diagnostic Services	100%	$0	$0

Parts A and B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care Medicare Approved Services Medically necessary skilled care services and medical supplies			
--Durable medical equipment	100%	$0	$0
First $[135] of Medicare-Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

Other Benefits—Not Covered by Medicare

Foreign Travel--Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan N
Medicare (Part A)—Hospital Services—Per Benefit Period

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

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068] (Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: --While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
Once lifetime reserve days are used: --Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
--Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
Blood First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

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

Plan N (continued)
Medicare (Part B)—Medical Services—Per Calendar Year

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses—In or Out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $[135] of Medicare-Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
Blood First 3 pints	$0	All Costs	$0
Next $[135] of Medicare-Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services—Tests for Diagnostic Services	100%	$0	$0

Parts A and B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care Medicare Approved Services Medically necessary skilled care services and medical supplies			
--Durable medical equipment	100%	$0	$0
First $[135] of Medicare-Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

Plan N (continued)
Other Benefits—Not Covered by Medicare

Foreign Travel – Not Covered By Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

E. - E.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1111 (re-designated from LSA-R.S. 22:224 pursuant to Acts 2008, No. 415, effective January 1, 2009) and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1114 (June 1999), repromulgated LR 25:1495 (August 1999), amended LR 29:2449 (November 2003), LR 31:2918 (November 2005), LR:35:1121 (June 2009).

§565. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or any 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 presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

B. - G. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1111 (re-designated from LSA-R.S. 22:224 pursuant to Acts 2008, No. 415, effective January 1, 2009) and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1130 (June 1999). repromulgated LR 25:1510 (August 1999), LR 29:2474 (November 2003), amended LR 31:2937 (November 2005), LR:35:1135 (June 2009).

§591. Prohibition Against Use of Genetic Information and Requests for Genetic Testing

A. This Section applies to all policies with policy years beginning on or after May 21, 2009.

1. An issuer of a Medicare supplement policy or certificate;

a.. 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. 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.

2. Nothing in Subsection A.1 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 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).

3. 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.

4. Subsection A.3 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) and consistent with Subsection A.1.

5. For purposes of carrying out Subsection A.4, an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

6. Notwithstanding Subsection A.3, 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 following conditions 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 secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this Subsection, including a description of the activities conducted.

e. The issuer complies with such other conditions as the secretary may by regulation require for activities conducted under this Subsection.

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

8. 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.

9. 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 Subsection A.8 if such request, requirement, or purchase is not in violation of Subsection A.7.

10. For the purposes of this Section only:

a. *Issuer of a Medicare Supplement Policy or Certificate*—includes third-party administrator, or other person acting for or on behalf of such issuer.

b. *Family Member*—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*—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*—a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

e. *Genetic Test*—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*—

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 creation, renewal, or replacement of a contract of health insurance or health benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1111 (re-designated from LSA-R.S. 22:224 pursuant to Acts 2008, No. 415, effective January 1, 2009) and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 35:1135 (June 2009).

§599. Effective Date

A. This regulation shall become effective upon publication in the *Louisiana Register*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:1111 (re-designated from LSA-R.S. 22:224 pursuant to Acts 2008, No. 415, effective January 1, 2009) and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1142 (June 1999), repromulgated LR 25:1522 (August 1999), amended LR 29:2497 (November 2003), LR 31:2948 (November 2005), LR 35:1136 (June 2009).

James J. Donelon
Commissioner

0906#018

RULE

Department of Public Safety and Corrections
Office of State Police

Training and Education (LAC 55:I.301)

Under the authority of the State Police Law, R.S. 40:1375(F), and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Office of State Police hereby amends Section 301 under Chapter 3 to amend the user fees at LSP Training facilities.

Title 55
PUBLIC SAFETY
Part I. State Police

Chapter 3. Training and Education

§301. User Fees for Louisiana State Police Facility

A. The Louisiana State Police announces maximum user fees for its training facilities pursuant to R.S. 40:1375(F) according to the following schedule.

Louisiana State Police Training Facility Rates	
* * *	
Conference Center Lodge Rooms	
Lodges 3-6	$70 single/$90 double (GOVT)
	$70 single/$90 double (COMM)
VIP Lodge Rooms	$100 single/$100 double
* * *	

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1375 (F)

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Police, LR 12:116 (February 1986), amended LR 26:95 (January 2000), LR 26:2626 (November 2000), LR 34:94 (January 2008), LR 35:1136 (June 2009).

Jill P Boudreaux
Undersecretary

0906#041

RULE

Department of Revenue
Office of Alcohol and Tobacco Control

Regulation V—Solicitors
(LAC 55:VII.309)

Under the authority of R.S. 26:793, and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Revenue, Office of Alcohol and Tobacco Control, has amended LAC 55:VII.309 relative to the minimum qualifications for successful applicants for Solicitors Permits.